REGULATORY FOCUS BULLETIN

INTRODUCTION

Since its inception in July 1991, the Regulatory Focus Bulletin has served as an important tool for both regulators and providers in North Carolina. RFB is designed to provide clarification of state and federal law, and Nursing Home Licensure and Certification policy in matters relating to the state's nursing facilities. RFB is a joint effort between the NC Department of Health and Human Services, Division of Health Service Regulation and the North Carolina Health Care Facilities Association. Answers and information provided in RFB are agreed upon by both DHSR and the Association and, pursuant to the premise upon which RFB is founded, are binding upon both the regulatory agency and the provider. RFB is the only publication of its type for long term care providers in the country, making it a truly unique contribution in the ongoing effort to ensure quality care in North Carolina's nursing facilities.

Regulatory Focus Bulletin has addressed hundreds of questions on such topics as infection control, nursing practice issues, physical plant requirements, Omnibus Budget Reconciliation Act requirements, and licensure requirements, to name a few. RFB was originally published monthly, with each month's issue addressing any questions raised during that time. Because of the volume of answers provided during its history, RFB was sometimes difficult to utilize. RFB users had to search through back issues looking for answers to important questions.

In early 1993, the RFB committee undertook the ambitious project of organizing over four years of RFB answers into a new, easier-to-use format. The RFB committee also revisited every prior RFB question and answer to determine whether answers were still correct. Those which were no longer applicable because of changes in the law or policy were revised. This process took over six months. The fruit of that labor is the RFB notebook you are now holding.

In this new format, all questions ever answered in RFB have been grouped under one of thirteen topics. The topics are divided by labeled tabs for easy access and pages within each section are numbered sequentially. Each answer is also dated to reflect the date on which the answer was published or revised. In addition, at the back of some sections readers will find yellow pages labeled "For Your Information." These sheets contain information, which DHSR and the Association believe may be helpful to regulators and providers, even though it may not be provided in response to a specific question.

As new questions are answered periodically by the RFB committee, subscribers will receive each answer on an individual sheet which indicates the tab behind which the page should be placed. Each sheet also will be numbered to indicate where within a section it belongs. As law or policy changes and answers need to be revised, subscribers will be provided new answers which indicate the page or pages they are replacing and where to place them in the notebook. Finally, inclusion of the date at the bottom of each page will allow readers to know at a glance when answers were provided.

As always, RFB will continue to provide statutory and regulatory interpretations where appropriate, and to address matters of concern or uncertainty raised by providers or regulators. The issues addressed by RFB are limited primarily to matters within the regulatory purview of DHSR. Occasionally, however, RFB may address an issue not subject to DHSR regulation by relying upon agencies, organizations or experts outside DHSR. In such cases, the source of information provided will be identified.

Occasionally, providers raise questions for which no statutory or regulatory answer exists. In these instances, where appropriate, RFB may offer practice tips or suggested approaches to aid readers. Information of this nature is designed to identify possible approaches only, not to create new mandatory procedures or requirements. Where such information is provided, the text will clearly indicate that it is a suggestion or one of several possible approaches only, not a requirement.

We hope you find the new and improved RFB helpful. Many thanks to the DHSR regulators and the NCHCFA staff and members who spent countless hours reading, researching, negotiating, copying, and collating to recreate RFB in its new format. The 1993 RFB committee dedicates these efforts and this publication to the continuous quest for excellence and quality in the delivery of long term care services.

ADMINISTRATION

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FILE TOPIC: Administration

Currently, rest homes cannot charge the resident for laundry costs. Can you charge the rest home resident in a combination facility?

No. Home for the aged or rest home beds in combination facilities are surveyed according to the freestanding regulations (Home for the Aged and Disabled Regulations). According to regulation 10 NCAC 42C .2305(c)(1) and (2), "Laundry services must be provided to residents without any additional fee. It is not the home's obligation to pay for a resident's personal dry cleaning and the resident's plans for personal care of clothing are to be indicated on Form DSS-1865, the Resident Register."

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FILE TOPIC: Administration

Does F159 {483.10(c)(4)} require facilities to distribute financial records through quarterly statements to residents?

Yes. The interpretive guidelines state "quarterly statements are to be provided in writing to the resident or the resident's representative within 30 days after the end of the quarter."

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FILE TOPIC: Administration

Is it a violation of a rule or requirement if a facility does not provide both a smoking and nonsmoking employee break room?

No.

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FILE TOPIC: Administration

If a resident has $65.00 in a resident account, is it permissible for interest to apply only on the amount in excess of $50.00?

Yes. The rule says that a patient's personal funds over $50 ($100 for Medicare residents) must be deposited in an interest-bearing account, and accrued interest (less bank fees) must be allocated to the individual patients.

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FILE TOPIC: Administration

What are the responsibilities of the facilities to keep their policies updated?

There is no licensure rule or federal regulation that directly addresses this question. However, it is a standard of practice for facilities to keep their policies updated.

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FILE TOPIC: Administration

Is there a Medicare or Medicaid regulation that requires information about how to apply for Medicare or Medicaid to be posted in each patient's room?

No. 42 CFR 483.10(G)(a) requires the facility to prominently display written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by Medicare or Medicaid. However, there is no requirement that the information be posted in each resident's room.

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FILE TOPIC: Administration

Is it appropriate for Licensure and/or Certification to request copies of a new facility's policy and procedure manuals prior to the initial survey? If appropriate, what assurance does the nursing home have that these policies and procedures will not be shared with other providers? Will the copyright be respected?

No. It is not appropriate for Licensure and/or Certification to request copies of a new facility's policy and procedure manuals prior to the initial survey.

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FILE TOPIC: Administration

What is a reasonable time frame for reimbursement of funds to patients/families? For example, a month's stay is paid in advance by patient/family. The patient is discharged before the month is completed.

Upon discharge or transfer to another facility, an accounting of patient's funds and property must be completed, paid, and delivered within thirty days. Upon the death of a Medicaid patient, his or her balance in the personal needs fund must be accounted for and turned over to the administrator of the estate within thirty days after death. If no administrator has been appointed, the balance will be disbursed by the Clerk of Superior Court within thirty days after death. The funds and personal property will be disbursed by the Clerk of Superior Court under the provisions of North Carolina General Statute §28A-25-6. Funds should be sent to the Clerk of Superior Court of the county which was providing the Medicaid assistance. The letter remitting the funds should have the patient's full name, date of death, Medicaid ID number, and the name of the county department of social services that provided medical assistance.

Above statement "4701.36" from Medicaid Manual Long Term Care Facilities, published by EDS Federal Corp. for the North Carolina Division of Medical Assistance.

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FILE TOPIC: Administration

What information is required when reporting abuse, neglect, or misappropriation of property to DFS, and what are the timeframes for reporting?

Please refer to Licensure Rule .2210 Reporting Abuse, Neglect or Misappropriation.

Licensure rule 3H .2210(b) states: "The administrator shall ensure that the Complaint Investigation Branch of the Division of Facility Services is notified within 24 hours or as soon as practicable of all allegations which appear to a reasonable person to be related to patient abuse, neglect or misappropriation of patient property." 3H .2210(d) states: "The administrator shall ensure that the report of investigation is printed or typed and postmarked to the Complaint Investigation Branch of the Division of Facility Services within five working days of the allegation. The report shall include the date and time of the alleged incident of abuse, neglect or misappropriation of property; the patient's full name and room number; details of the allegation and any injury; names of the accused and any witnesses; names of the facility staff who investigated the allegation; results of the investigation; and any corrective action that may have been taken by the facility."

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FILE TOPIC: Administration

Does a provider have a right to be notified about, be present and speak about a penalty being discussed at the Penalty Review Committee meeting?

Yes. The facility receives written notification from the Division of Facility Services concerning recommendations to be reviewed by the Penalty Review Committee. This correspondence also includes the date, time and location of the meetings, as well as the facility's options, which include the opportunity to present additional information or verbal testimony to the committees. Please refer to Licensure rule 3H .2111.

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FILE TOPIC: Administration

What is the requirement for minimums on the surety bond or self insurance on residents' trust accounts?

No minimum is specified. However, 42 CFR 483.10(c)(7) does mandate that the coverage "assure the security of all personal funds of residents deposited with the facility." For further information refer directly to the Interpretive Guidelines.

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FILE TOPIC: Administration

How long do facilities need to maintain Quality Assurance auditing records before they dispose of them?

Quality Assurance auditing records are to be maintained based on facility policy. There is no regulation that dictates a time frame.

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FILE TOPIC: Administration

Are facilities required to notify the Board of Nursing of patient abuse by nurses?

Yes. Regarding abuse of patients by licensed nurses, the Board of Nursing refers all employers to the Nurse Practice Act, N.C. General Statute §90-171.47. This statute provides as follows: "Any person who has reasonable cause to suspect misconduct or incapacity of a licensee or who has reasonable cause to suspect that any person is in violation of this Article...should report the relevant facts to the Board."

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FILE TOPIC: Administration

Should withdrawals from patients' personal funds for payment of beautician services that are not covered by Medicaid be documented?

Yes. All withdrawals from patients' personal funds accounts, including those for payment of non-Medicaid-covered barber or beautician services must be documented. Reference is made to the Medicaid Manual for Long-Term Care Facilities (a.k.a. the Medicaid Provider Manual), Section 4703 (page 4-34), which states:

> For ease of accounting, the facility should maintain a patient personal funds Petty Cash Account with two hundred dollars ($200.00) more or less, depending on the size of the facility. The use of pre-numbered cash disbursement receipts is essential in accounting for the Petty Cash Account. Use of a Petty Cash Account and a signed pre-numbered cash disbursement receipt will be adequate documentation and will eliminate the need to write a check each time a patient needs money. All withdrawals from the patient personal funds account must be documented with a cash disbursement receipt or a canceled check. Cash disbursement receipts that have the mark of a patient must contain the signature of a witness.

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FILE TOPIC: Administration

Federal and NC Licensure requirements require the "use of the services of a Registered Nurse" 8 consecutive hours, 7 days a week. Does the RN have to be physically present in the facility or available and on-call?

The RN must be physically present in the nursing home facility/unit.

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FILE TOPIC: Administration

Should facilities accept telephone orders for "no code"?

Whether to accept telephone "no code" is within the discretion of the facility and should be the subject of facility policy. Individual facilities need to clearly define their requirements for acceptance and for signature by the physician issuing the order.

No code orders (DNR orders) must be issued only by the attending physician and must be in writing. Facilities may opt to allow for telephone no code orders with procedural safeguards such as requiring that two staff persons hear the order and that the physician countersign the no code order within a designated time.

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FILE TOPIC: Administration

Is CPR training required for licensed staff?

Based on the responsibility of the nursing home to provide sufficient qualified staff to meet patients' needs, it would be expected that someone be on duty at all times who is able to initiate CPR in the event of cardiopulmonary arrest. Training in basic life support is the most frequently documented means of ensuring that this emergency care need can be met. Being certified in basic life support is not required unless the facility wishes to make it policy. The American Heart Association recommends that CPR training be obtained at least once a year.

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FILE TOPIC: Administration

Is a facility required to do TB screening for respite care residents?

Yes.

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FILE TOPIC: Administration

Is there a requirement for notifying DFS regarding vacancies in positions of administrator and/or director of nursing?

Yes. Licensure rule 3H .2104 requires a facility to notify the Medical Facilities Licensure Section of DFS within one working day following a change in administrator or a change in the director of nursing.

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FILE TOPIC: Administration

What are the requirements for calculating emergency water supplies?

The intent of the regulation is that the facility has a method to assure that they have an adequate water source at the time of an emergency. The regulation states that the facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply.

The facility's responsibility is to have a written protocol which defines the source of water provision for storing the water, both potable and non potable. The protocol should include a method for distributing water, and a method for estimating the volume of water required. The survey protocol asks the questions at the entrance conference about the facility's procedure to ensure water availability.

There is no regulation or direction that indicates:

1. What should be in the protocol? It is up to the facility to do this. The protocol should indicate where they are getting the water from (i.e. vendors, national guard, red cross, or a system with their county Emergency Management System, etc) and if they are keeping the water on site (which is not required) how they are storing the water and how it is maintained. Surveyors should look at the water supply if it is being kept on site.

2. The regulation does not say how they have to distribute the water, just that the there is a method for distributing the water. This method should be outlined in the protocol that the facility has developed. It would be expected that the protocol would indicate time frames if there were long term water availability problems.

3. How the facility has to estimate the volume of water that is required, just that they have to determine the volume of water and have a process for it to be available. The facility would determine whatever method it chooses to determine the volume of water that is needed. There are many different ways that this is accomplished such as the facility being in contact with emergency management officials in the county, they usually have a method for determining water volume. The Red Cross is a resource that can assist with providing a way to calculate water volume. The National Guard is also a source that facilities have used to provide water in an emergency. The facility should be able to show the surveyor how the water volume was calculated. This calculation method would normally be found also in the protocol, but it is up to the facility to choose the calculation method.

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FILE TOPIC: Administration

May long term care staff other than licensed nurses or Nurse Aide Is feed patients?

Yes. Any employee who has been trained in basic feeding techniques and the proper procedures to follow in the event of choking (including the Heimlich maneuver) may feed patients who through documented assessment have been determined not to have complications with chewing and swallowing. This training should be documented in the employee's personnel file.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

May facilities have contracts with, or otherwise require employees to repay a facility for nurse aide training and competency evaluation programs or competency evaluation programs if the employee does not remain with the facility for a specified period of time? May nursing facilities charge, or otherwise require employees to assume responsibility, for costs associated with nurse aide training and competency evaluation programs or competency evaluation programs?

No. [from the preamble to the final regs]: "The cost of nurse aide training and competency evaluation is borne by the Medicare and Medicaid programs. It is inappropriate for a facility to ask a nurse aide to repay the facility for an expense for which it has already been paid." Further, "No programs that charge fees to any nurse aides who are employed by, or who have an offer of employment from, a facility may be approved by the State."

42 CFR 483.152(c)(1) and 42 CFR 483.154(c)(2) of the final regulations prohibit an aide who is employed by, or who has received an offer of employment from, a facility on the date on which the aide begins a nurse aide training and competency evaluation program or competency evaluation program, being charged for any portion of the program, including any fees for textbooks or other required course materials. Further, if the individual receives an offer of employment from a nursing facility within 12 months of completing an NAT/CEP or CEP, the State will provide for reimbursement on a pro rata basis. 42 CFR 483.158 of the final regulations provide FFP for nurse aide training and competency evaluation.

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FILE TOPIC: Administration

Does the facility have to post the physician's name and telephone number in the resident rooms?

No. Federal requirement 42 CFR 483.10(b)(8) states that the facility must inform each resident of the name, specialty and way of contacting the physician responsible for his or her care. The manner in which residents are informed of their physician is at the discretion of the facility.

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FILE TOPIC: Administration

Can a provider charge a Medicare patient for haircuts and personal laundry costs?

No. The Medicare Skilled Nursing Facility Manual, 230.10(B) states "Routine Personal Hygiene Items and Services. Routine personal hygiene items and services required to meet needs of residents are covered items and services. These include but are not limited to: hair hygiene supplies; combs; brushes; bath soaps; disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or fight infection; razors; shaving cream; toothbrushes; toothpaste; denture adhesive; denture cleansers; dental floss; moisturizing lotion; tissues; cotton balls; cotton swabs; deodorant; incontinence care and supplies; sanitary napkins and related supplies; towels; wash cloths; hospital gowns; over-the-counter drugs; hair and nail hygiene services; bathing; and basic personal laundry."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

What is a facility's obligation to provide therapy (PT/OT/ST) that has been ordered by a physician when coverage/funding is exhausted?

The facility is obligated to meet the patient's needs for services. Patient needs and physician orders cannot be ignored due to inadequate funding. The unavailability of funds to purchase needed treatment should be discussed with the patient and/or patient's representative. The Department of Social Services should also be involved in the resolution of financial problems. If a funding source has not been established after exploring all possible funding options, the attending physician should be notified to determine if alternate measures may be employed to meet the patient's needs. However, if there are not acceptable alternatives which adequately meet the patient's needs, the services must be provided as ordered.

Please note: Both Medicare Part B and Medicaid cover physical, occupational, and speech therapies. Since Medicaid is the payor of last resort, Medicare Part B must be billed before the provider can list therapy expenses on the Medicaid Cost Report. Medicare co-payments may be billed to Medicaid when the patient is covered by both.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

Please clarify any discrepancy between OBRA regulation 42 CFR §483.40(c) Interpretive Guidelines (Physician Services) (Certification) and Licensure rule .2501 concerning when and what kind of visits PAs/NPs may make and when physicians are required to visit.

In all licensed facilities, patients shall be seen by a physician at least once every 30 days for the first 90 days and at least once every 60 days thereafter. Following the initial visit, required visits by the physician may be alternated with a physician's assistant or nurse practitioner. (See Licensure rule .2501(b).)

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FILE TOPIC: Administration

Must a facility skin-test a patient for tuberculosis if the patient is admitted from a hospital with a documented negative chest x-ray done within the week prior to admission?

Yes. Licensure rule [10NCAC 03H .2209(d)] requires communicable disease screening, including tuberculosis, prior to or upon admission of all patients admitted from hospitals. The Communicable Disease rule [15A NCAC19A .0205(b)(4)] requires patients shall be skin tested for tuberculosis and given appropriate clinical, microbiologic and x-ray examination in accordance with the "Diagnostic Standards and Classification of Tuberculosis", published by the American Thoracic Society, upon admission to a long term care facility. The two-step skin test method shall be used if the individual has not had a documented tuberculin skin test within the preceding 12 months.

While a negative chest x-ray may provide some evidence that the patient has no active, pulmonary disease, it does not rule out the possibility that the patient has a tuberculosis infection. Skin-testing can detect tuberculosis infection that has not yet resulted in disease.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration
DATE: October 1996

If the patient has died, may his/her former health care agent (under a health care power of attorney) or attorney-in-fact (under a general power of attorney) obtain the patient's medical records?

No. A health care power of attorney and a general power of attorney are automatically extinguished when the patient dies.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration
DATE: October 1996

If a survey team finds past noncompliance that has been fixed, should it be cited?

If the facility has been out of compliance with a regulatory requirement between two surveys in which they were in compliance, that past noncompliance will not be cited by the survey team if a quality assurance program is in place and has corrected the noncompliance. An exception to this policy may be made in cases of egregious past noncompliance.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration
DATE: October 1996

If a staff member is fired for patient abuse and the facility properly files a report with DFS, is the facility also required to notify the State Division of Social Services or the local Department of Social Services?

The answer depends on whether the patient is an adult or child. If the patient is an adult, and not in need of Adult Protective Services, there is no reporting requirement other than the report to DFS. If the patient is a juvenile (under age 18 and unmarried), State law requires any person or institution who suspects that any juvenile is abused (or neglected or dependent) to report the case to the local Department of Social Services. The report may be made orally, by telephone, or in writing.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration
DATE: October 1996

How do regulations address the transfer of residents within the same Medicaid certified facility?

Transfer within the same Medicaid certified unit is considered a roommate change rather than a discharge or transfer, unless the move is from a Medicare/Medicaid distinct unit, i.e., SNF/NF unit to a Medicaid distinct unit, i.e., NF unit. If the move is from a Medicare/Medicaid distinct unit to a Medicaid distinct unit, the move is considered a transfer and is governed by the transfer and discharge regulation at 42 CFR §483.12(a). If the move is from a NF to a SNF/NF, this is considered a roommate change. A resident has the right to refuse a room change if the purpose of the move is to obtain eligibility for Medicare. The resident must receive prompt notice before the room or roommate is changed. However, the regulation does not define the term "prompt" in terms of a minimum number of days. A 30 day notice is not required for a roommate change. Resident preferences and timing should be taken into consideration.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration
DATE: October 1996

What are the requirements regarding the posting of survey results?

Federal regulation 42 CFR §483.10(g)(1)(2), Examination of Survey Results, states that a resident has a right to examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility. The results must be in a place readily accessible to residents. The facility must make the results available for examination and must post either the results themselves or a notice of their availability.

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FILE TOPIC: Administration

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FILE TOPIC: Administration
DATE: November 1996

When deficiencies cite X of Y items found, how are the X citations to be communicated to the nursing facility to allow the nursing facility to correct specific incidents and validate (or dispute) the citation?

The facility will be informed of specific tag numbers cited and their placement on the grid upon receipt of the HCFA-2567. At that time it is appropriate to inform DFS of the intention to appeal. At the exit conference, the facility will be informed of the "483" number and the specific area of concern. The specific tag number and grid placement is not announced at this time as it is subject to review of management.

The determination of whether or not the facility has failed to meet one or more of the regulatory requirements is not determined until task number 6 which is "Information Analysis and Deficiency Determination." For more detailed information regarding this task refer to the State Operations Manual, Transmittal Number 274, page P-41. This task is performed at the end of the survey after all data has been collected and verified.

As surveyors interview the staff to obtain more information and confirm findings, the staff is made aware of specific issues and concerns. It is expected that there will be open communication between facility staff and surveyors throughout the survey process, initiated by either the facility staff or the surveyor.

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FILE TOPIC: Administration

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REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration
DATE: January 1997

Are facilities required to conduct a criminal record investigation for employees?

"No" for existing employees. "Yes" for applicants for employment beginning January 1, 1997. State law requires facilities to request a criminal background check from the State Bureau of Investigation on unlicensed applicants for employment. Other existing State law allows, but does not require, facilities to request criminal background checks on current employees (as opposed to applicants).

REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

Does the Plan of Correction completion date have to be by the date certain?

Yes. Plan of Correction (PoC) dates must be on or before the date certain. In addition, dates of allegations of compliance, if different from the PoC date, must be by the date certain.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

Why are "penalty" letters being sent to facilities who report patient abuse/neglect via incident reports?

DFS does not send out penalty letters in response to receiving incident reports of patient abuse or neglect.

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FILE TOPIC: Administration
DATE: January 1998

Is there a regulation that requires a nursing facility to have a pay phone on its premises?

No.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration
DATE: March 1998

Does the MDS automation requirement affect patients in “licensed only”, non-certified beds?

No.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration
DATE: August 1998

How much may facilities charge for copying medical records?

According to Federal regulation §483.10(b)(2), "the resident or his or her legal representative has the right to purchase at a **cost not to exceed the community standard** photocopies of the records or any portions of them upon request, and 2 working days advance notice to the facility." The interpretive guidelines define community standard (in the absence of State law) as "that rate charged per copy by organizations such as the public library, the Post Office or a commercial copy center, which would be selected by a prudent buyer in addition to the cost of the clerical time needed to photocopy the records. Additional fees for locating the records or typing forms/envelopes may not be assessed."

There is no State statute governing the copying of medical records except in personal injury cases (N.C. G.S. §90-411). This statute provides a maximum fee of $.50 per page with a $10 minimum for medical records.

When copying records for residents or their legal representatives, the federal regulation applies unless the copies are specifically for a personal injury case.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration
Date: October 1999

Preface: Rules pertaining to physician services are found at 483.40, tag numbers F385-F390. For the purposes of the rule, physician extenders include physician assistants, nurse practitioners, or clinical nurse specialists and are defined in the interpretive guidelines for 483.40(e) found at tag number F390. The extent of their practice is defined by individual state licensing boards; and they must be under the supervision of the physician.

What are the "required physician tasks" referenced in the rule?
The required physician tasks are:

- Personally approve in writing a recommendation that an individual be admitted to a facility…(F385).
- Physicians must see each patient at least once every thirty days for the first ninety days after admission and at least once every 60 days thereafter (F387).
- Review the plan of care at each required visit, write signs and date progress notes at each visit and sign and date orders (F386).

In SNF distinct parts or dually certified beds (SNF/NF) may a physician delegate the required tasks of visiting the patient for every other visit after the initial visit and other "required tasks" whether the physician extender is employed or not employed by the facility and working in collaboration with the attending physician?

Yes. (F388) (F390)

In a NF distinct part, may any "required task" be delegated to a physician extender who is not employed by a facility?

Yes. (F390)

In a NF distinct part, may tasks other than the "required tasks" be delegated to a physician extender who is employed by the facility, i.e., assessment between required visits, orders, progress notes, etc. other than those required in 483.40?

In a distinct part NF the required tasks, i.e., recommending admission to a facility; and of writing progress notes and signing and dating orders at each visit required once every 30 days x 90 days after admission and once every 60 days thereafter; may not be delegated to a physician extender who is employed by a facility. Other interim tasks, not required by this rule may be delegated to physician extenders employed by a facility, in collaboration with the patient's attending physician. In all cases, delegation to a physician extender does not relieve the physician of the obligation to visit a resident when the resident's medical condition makes that visit necessary (F388).

REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration
Date: November 1999

In a continuing care retirement community with homes for the aged beds licensed as a part of a nursing home, is it permissible to have a home for the aged resident in a skilled bed?

Yes. However, you cannot put a nursing home level patient in a HA bed.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration
Date: November 1999

Can a Medicaid recipient who has had a 3-day hospital stay, and meets medical criteria for Medicare coverage refuse to transfer to the Medicare designated unit upon return from the hospital?

Yes. All recipients have a right to refuse transfer to a Medicare-designated unit however, the answer to the second question will explain that they would have to pay for the NF service.

If the resident refuses to transfer, will Medicaid still pay?

No. The following documented excerpt from correspondence received from HCFA, November 27, 1996 states: "In most cases involving dual eligibles (Medicare/Medicaid), there is a probable existence of Medicare liability. Providers should bill Medicare before Medicaid, unless there is no Medicare eligibility or coverage and the provider furnishes such confirmation to Medicaid. The Medicare statute (Section 1866(a)(1)(A)) of the Social Security Act (the Act) requires Medicare providers not to charge anyone, including Medicaid, for items or services for which the individual is entitled to have payment made under Medicare (or for which the individual would be so entitled if the provider had complied with the procedural or other requirements under Medicare). A provider's violation of this requirement may cause termination or nonrenewal of the Medicare provider agreement in accordance with section 1866(b)(2) of the Act."

Administrative Code 10-26H .0209

"(d) In all circumstances involving third party payment, Medicaid is the payor of last resort. No payment will be made for a Medicaid recipient who is also eligible for Medicare, Part A, for the first 20 days of care rendered to skilled nursing patients. Medicaid payments for co-insurance for such patients will be made for the subsequent 21st through the 100th day of care. The Division of Medical Assistance will pay an amount for each day of Medicare Part A inpatient co-insurance, the total of which will equal the facility's Medicaid per diem rate less any Medicare Part A payment, but no more than the Medicare coinsurance amount, effective for such services beginning August 1, 1991. In the case of ancillary services providers are obligated to: (1) maintain detailed records or charges for all patients; (2) bill the appropriate Medicare Part B carrier for all services provided to Medicaid patients that may be covered under that program; (3) allocate an appropriate amount of ancillary costs, based on these charge records adjusted to reflect Medicare denials of coverage, to Medicare Part B in the annual cost report; and (4) properly bill Medicare or other third-party payors or have disallowance of any related cost claimed as Medicaid cost."

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FILE TOPIC: Administration
DATE: November 2000

If a facility has terminated an employee and has informed the employee they are not to return to the facility due to the facility's determination that the former employee's conduct would jeopardize residents' safety or well-being, and/or disrupts the staff's ability to provide services can the facility refuse the former employee access to visit residents?

Yes. According to CFR 483.10(j)(1)(viii) "Visitation rights are subject to reasonable restrictions... However, this does not mean that any fired employee can be prohibited from visiting a resident in the facility. If there is no reason or evidence that the terminated employee would jeopardize other residents' safety/well-being or disrupt other employees providing services to residents, then the terminated employee should be allowed to visit those residents who request his/her presence."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration
DATE: April 2001

Can facilities refuse to allow sitters to provide services to patients in the form of limiting tasks or access to patients based on facility policy? Examples: deny access to patient because of sitter's refusal to be screened for drugs or participate in criminal background checks (if facility policy for sitters) or to limit tasks performed by the sitter such as transferring a fragile or heavy patient.

Yes. The facility is responsible for the care and services of their residents, including protecting them from abuse and neglect.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration
DATE: August 2001

When a nursing facility patient is in the hospital overnight or longer, must they re-sign the following components of the admission packet in order to comply with regulatory requirements?

1. Acknowledgement of explanation of resident's rights (assuming none have changed in the interim
2. Admission agreement
3. Financial responsibility and explanation of charges
4. Consents for treatment
5. Privacy Act notification
6. Medical records releases
7. Ancillary services agreements
8. Medicare and Medicaid eligibility explanations and assignments
9. Explanation of facility rules and policies (assuming none have changed)
10. Patient trust fund information
11. Advanced Directives information

Answer: Federal regulations do not specifically address this issue. However, facility policies and procedures should address whether or not the documents must be re-signed including advanced directives upon the resident's return to the facility.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration
DATE: January 4, 2005

For each document of a resident's medical record in which a licensed or unlicensed caregiver enters their initials I lieu of their signature, must there also be a signature somewhere on that same document that corresponds to those initials?

Yes, unless the facility uses a master signature sheet.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration
DATE: May 6, 2005

What is the definition of an injury of unknown origin as stated in 483.13 (c) (2)?

The Centers for Medicare and Medicaid Services issued the following clarification in December 2004.

Injuries of unknown source - An injury should be classified as an "injury of unknown source" when both of the following conditions are met:

- The source of the injury was not observed by any person **or** the source of the injury could not be expla ined by the resident; **and**,
- The injury is suspicious because of the extent of the injury **or** the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) **or** the number of injuries observed at one particular point in time **or** the incidence of injuries over time.

http://www.cms.hhs.gov/medicaid/survey-cert/sc0509.pdf

REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration
Date: August 2006

What safety requirements are required for securing a resident in a wheel chair in a transport van?

Neither Federal long term care requirements nor state licensure rules specify requirements for securing a resident in a wheel chair during van transportation.

Click on link for more information:

http://facility-services.state.nc.us/RideSafe.pdf

REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration
DATE: March 2007

Is there a regulatory requirement that the Matrix Roster be updated weekly by the facility? If so, please give reference.

There is no regulatory requirement for updating the Roster/Sample Matrix (Form CMS-802) on a weekly basis. During a recertification survey, this form is needed by the end of the initial tour (Appendix P P-23).

REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration
DATE: March 2007

The NC statute regarding portable DNR forms protects medical personnel from liability if they do not resuscitate individuals for whom this form is completed and in their possession. Is there a regulation that requires the form be given to unlicensed personnel such as NAs, activities staff or friends and relatives who take individuals with such forms in their medical records on social outings in non-medical transport?

No.

REGULATORY FOCUS BULLETIN
FOR YOUR INFORMATION

FILE TOPIC: Administration

NOTE: "FYI is an informational and educational service of the Regulatory Focus Committee to assist you in finding the resources for answers to questions regarding issues not regulated by the Division of Health Service Regulation. The source of the information is included for your reference.

Do health care workers that have been vaccinated for Hepatitis need to be titer-tested post vaccination?

Yes. Health care workers must be titer tested 30-60 days after finishing the Hepatitis B vaccination series. If the test shows they responded then they never have to be titer tested again, even if they have a needle stick, because once positive always protected. There is no need to titer test people who had completed the vaccines more than 6 months ago as people's titers naturally wane over time and the results would be unreliable. The optimal time for determining immune response to the vaccine is one to two months after the third dose.

Per the OSHA document CPL 2-2.69, Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens, Nov 27, 2001 the following applies to Hepatitis B serologic testing of vaccinated employees. Paragraph (f)(l)(ii)(D). This paragraph takes into consideration the changing nature of medical treatment relating to Hepatitis B. The CDC is the US Public Health Service (USPHS) agency responsible for issuing guidelines and making recommendations regarding infectious agents. OSHA requires employers to follow the CDC guidelines current at the time of the evaluation or procedure. Copies of the current guidelines and other CDC documents can be obtained on CDC's Web site, http://www.cdc.gov/. The hepatitis B vaccination must be given in the standard dose and through the standard routes of administration as recommended in the USPHS/CDC Guidelines. The most current CDC guideline regarding Hepatitis B is the Updated US Public Health Service Guidelines for the Management of HBV, HCV, and HIV and recommendations for Postexposure Prophylaxis published in the MMWR, Vol 50, No RR-11, June 29, 2001. (Attached as App E) It states that employees who have ongoing contact with patients or blood and are at ongoing risk for percutaneous injuries are to be tested for antibody to Hepatitis B at the completion of the vaccination series and must be revaccinated with a second three-dose vaccine series and retested, unless they are HbsAg-positive (infected). Non-responders must be medically evaluated.

Source: UNC School of Medicine- Infectious Disease etc.

CARE PLANS

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

A facility was cited for not involving the patient and family "enough" in the care planning process. This specific facility extends an invitation to the patient to attend the care planning process, but since the family usually can not attend, the family meets with the staff after the care plan has been developed to review and make changes to the care plan. The surveyor stated that the family had to be accommodated and present during the care planning process even if it meant holding care planning meetings at 7:00 pm at night.

There is no basis for such a citation. Regarding the care planning process, facility staff should refer to regulations 42 CFR §483.10(d)(1)-(3), tag F163, and 42 CFR §483.20(d)(2), tag F280. The emphasis on the care planning process is with resident involvement. Meetings should be scheduled to accommodate the resident's schedule/routine. Families should be involved if the resident is agreeable to this involvement or if the resident is incapable or otherwise incapacitated. Care plan meetings do not have to be scheduled to meet a family's working schedule, but this would facilitate their involvement in this process. Alternatives, such as a separate meeting to review, revise, and approve the plan would meet the regulation.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

Can more than three problems be addressed in a patient care plan?

Yes. Refer to Licensure rule .2301(c), which states, "The facility shall develop a comprehensive care plan for each patient and shall include measurable objectives and timetables to meet needs identified in the comprehensive assessment". Certification regulation CFR 42 §483.20(d), states, "The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing and psychosocial needs that are identified in the comprehensive assessment."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

In order to have the care plan easily accessible to the nursing assistants, can the care plan be placed at the bedside on a clipboard or in a folder? For confidentiality purposes the plan would be placed in a colored plastic slip before being put on the clipboard or in the folder. Also, can patient care information, like splints and positioning equipment be posted at the head of a resident's bed?

Yes, if the resident or resident's surrogate, representative, or responsible party gives consent.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

Does every medical problem have to be addressed in the patient care plan even if it is not a current problem?

No. Both Licensure and Certification have rules which require that the facility identify patient's current needs/problems, goals, and interventions (PCP) with evaluation of care at least quarterly and revision/updating as needed. A medical diagnosis does not automatically result in a patient "need". Further information should be gathered to clarify if there is a patient problem associated with the diagnosis.

An example of "no patient problem" might be a diagnosis of hypertension with a 5-10 year history of stable/normal blood pressure on medication therapy, and good dietary compliance. All the patient's needs are being met by the medication and diet orders and no nursing or other discipline intervention is needed to compensate for a deficit in the patient's ability to meet his own needs.

The Resident Assessment Instrument (RAI) through triggering mechanisms and resident assessment protocol review indicate which items should be considered through the care planning process.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

Are nursing diagnoses required on patient care plans? (Examples: ineffective airway clearance, impaired adjustment to facility, activity intolerance due to immobility)

No. There are no regulatory requirements for the use of nursing diagnoses on care plans. Patient care plans must identify "needs, goals, plans and effectiveness of intervention....in a timely manner."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

Must patient care plans reflect specific medications and treatments as an approach?

The care planning process dictates the appropriateness of inclusion of medications or treatments.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

Where should the social work care plan be found - with the interdisciplinary care plan or with individual social history and social work notes?

There is no regulatory requirement for a separate social work plan. Psychosocial needs are to be identified and incorporated into the resident's assessment and interdisciplinary care planning process along with all identified needs.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

Is there a requirement for a care planning conference?

There is no regulatory requirement for a care planning "conference". Interdisciplinary care planning may be carried out in many ways. The facility is free to choose the method which is best in any given situation.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

May facilities combine problems/needs on the care plan as dictated by the resident assessment protocols (RAPs)?

Facilities may combine problems/needs on the care plan as dictated by the resident assessment protocols (RAPs). In fact, in many cases RAP review should link together multiple indicators under one problem/need. The rationale for combining and linking problems should be included in the documented RAP review. Clinical disagreement does not equal non-compliance when the care planning rationales are clearly documented and are within acceptable standards of practice.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

Is there a requirement for acute episodes that do not result in significant or permanent change to be taken to the care plan?

No. There is no requirement for acute episodes that do not result in significant or permanent change to be taken to the care plan. Examples of these types of acute episodes are short term alterations in the residents physical and functional condition such as the flu; minor infections including readily resolved and nonrecurrent UTIs and URIs; minor injuries resulting from routine day to day living and not precipitated by a change in condition; non-acute and nonrecurrent GI disturbances; etc..

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

Is there a requirement for separate discipline specific histories, assessments, and progress notes such as dietary, social work, and activities (other than the MDS and RAP review)?

No. Separate discipline specific histories, assessments, and progress notes such as dietary, social work, and activities (other than the MDS and RAP review) are not required. Additional assessment is driven by the individual needs of each resident and the resident assessment protocols, and should follow the same interdisciplinary model. Progress notes are required for goals addressed on the care plan. Should problems be recognized by staff that are not triggered by the MDS, additional assessments and notes by disciplines may be indicated.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

Is there a requirement that each discipline list a problem/need on the care plan?

No. There is no requirement that each discipline list a problem/need on the care plan. There is no requirement that each problem/need have an approach listed for each discipline unless that discipline's intervention is indicated and appropriate.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

Are individualized approaches, rather than generalized approaches, required for effective care planning?

Yes. Individualized approaches, rather than generalized approaches, are required for effective care planning. Examples of generalized approaches that should not need to be listed on care plans include but are not limited to: "bathe", "dress", "feed", "groom", "nourishments". These terms result in "canned" plans that tend to address all problems generically for all patients with that particular need. Individualized care plans do not plan routine care but plan for the individualized approach necessary to accomplish that routine care. Individualized plans would address issues regarding a patient's bathing needs that are unique for him; what differing types of nourishments should be offered; etc..

Because strengths and weaknesses are considered during the RAP process, it is not necessary to list them on the care plan.

Task segmentation and goal segmentation (short term goals) should be used to individualize the care plan.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

Is there a requirement that dictates how facilities involve patients and physicians in care planning?

No. There is no requirement that dictates how facilities involve patients in their care planning. Input into the care planning process should be accomplished based on the individuals condition, capabilities, and preferences. This input may be accomplished in private discussions at the bedside or, if the patient chooses, in a conference setting. Similarly, there is no requirement that dictates the manner in which physicians participate in the care planning process.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

Are discharge plans or post discharge plans required for in-house transfers such as level of care changes?

No

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans
DATE: September 1996

Is it necessary to continue to review at each patient care conference vital parameters if all vital parameters are stable?

No. The regulation states that the comprehensive care plan must be, "periodically reviewed and revised...after each assessment." The assessment directs the review of the care plan. If vital parameters had been a problem on the care plan they would need to be reviewed to determine if they were still a problem. If vital parameters had been included in a goal, they would need review to determine if the goal had been reached or if the goal needed to be revised or eliminated.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans
DATE: September 1996

Does the Plan of Correction completion date have to be by the date certain?

Yes. Plan of Correction (PoC) dates must be on or before the date certain. In addition, dates of allegations of compliance, if different from the PoC date, must be by the date certain.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plan

Do facilities have to create a care plan document for every resident within 24 hrs of admission that includes problem/need measurable objectives, implementation of approaches, etc. in addition to the care plan developed as a culmination of the RAI process?

No, a "care plan document" is not required. The facility should assess and address specific resident areas that need to be managed via MD orders, treatment records, Medication Administration Records, assessments, etc. The records should contain evidence that the care is being provided as needed until the comprehensive assessment is completed.

The references below specifically state that the initial care plan process begins on day 1 and includes problems and immediate interventions.

The **Guidance to Surveyors for tag F281** (May 1999) states "Is there evidence of assessment and care planning sufficient to meet the needs of newly admitted residents, prior to completion of the first comprehensive assessment and comprehensive care plan?"

The **Guidance to Surveyors for tag F309** (June 1995) states, "If the resident has been in the facility for less than 14 days (before completion of all the RAI is required), determine if the facility is conducting ongoing assessment and care planning, and, if appropriate, care and services are being provided.

The Long-Term Care Resident Assessment Instrument User's Manual, Version 2.0 (December 2002) speaks to the formulation of the care plan. It says, "For an Admission assessment, the resident enters the facility on day 1 with a set of physician-based treatment orders. Facility staff typically reviews these orders. Questions may be raised, modifications discussed, and change orders issued. Ultimately, of course, it is the attending physician who is responsible for the orders at admission, which form the basis for care plan development.

On day 1, facility staff also begins to assess the resident and to identify problems. Both activities provide the core of the MDS and RAP process, as staff look at issues of safety, nourishment, medications, ADL needs, continence, psychosocial status and so forth. Facility staff determines whether or not there are problems that require immediate intervention (e.g., providing supplemental nourishment to reverse weight loss or attending to a resident's sense of loss at entering the nursing facility). For each problem, facility staff will focus on causal factors and implement an initial plan of care based on their understanding of factors affecting the resident."

DIETARY

DIETARY

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

Residents are to be served a snack if greater than 14 hours elapse between evening meal and breakfast. What food groups constitute a snack?

The Interpretive Guidelines refer to a "nourishing snack" which is an offering of items, single or in combination from the basic food groups. (Meat and poultry; fruit and vegetables; bread and cereal; milk and dairy products).

What is the appropriate manner in which to document a resident's intake of a nourishing snack?

There is no documentation requirement.

Is it acceptable to offer a snack or must a snack be prepared and delivered to each resident?

The regulation states that the facility must offer snacks at bedtime daily.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

How often should a registered dietitian make an entry in a patient record?

Although there is no regulatory requirement that specifies the frequency with which a consulting registered dietitian is to make notes in an individual patient's chart, the need to do so depends entirely upon the condition of the patient and the competencies of the dietary manager. Patients receiving tube feedings, with continued weight loss, renal failure, COPD, diabetes, and other high risk conditions may need to be documented by the dietitian at frequent intervals as dictated by patient needs. Licensure rule .2701(d) states: "The dietitian shall spend sufficient time in the facility to assure the following parameters of nutrition have been addressed and that recommended successful interventions have been met:

1. An analysis of weight loss or gain;

2. Laboratory values;

3. Clinical indicators of malnutrition;

4. Drug therapy that may contribute to nutritional deficiencies;

5. The amount of meal and supplement consumed to meet nutritional needs;

6. Increased nutritional needs related to disease state or deterioration in physical or mental status, i.e., decubitus, low protein status, inadequate intake, or nutrition provided via enteral or parenteral route."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

When a physician orders "in between meal snacks" is this interpreted as two times a day or three times a day?

When a physician orders "in between meal snacks" it is not clear to the surveyor whether this means between breakfast and lunch and lunch and dinner or if this should also include between dinner and breakfast. The facility should clarify through policy or physician orders what the intent of the order is and follow this intent.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

May dining rooms have bowls of salt and pepper and sugar packets on the tables for regular diet residents as long as the special diet residents receive the appropriate packets on their trays?

Yes. Regulation does not prohibit this practice; however, facilities must ensure that residents receive the diet prescribed by the physician.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

Can volunteers feed residents?

Yes, if the facility assures the person is capable and knowledgeable of the service provided. The Interpretive Guidelines for Federal regulations found at 42 CFR §483.75(c), tag 493 state, "Volunteers are not nurse aides and do not come under nurse aide training provisions..." The facility must ensure the safety of its residents in all circumstances. Facility risk management measures, such as training volunteers, are not prescribed by regulation.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

Can family members feed residents who are either on a regular or a special diet without receiving training as required of nurse aides?

Yes.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

When serving trays in the dining room, is it a requirement to serve all residents at one table, then the next table and so on, or can trays be passed sporadically?

While it is not a regulation that all residents at that table be served simultaneously, it is a possible violation of resident's rights if the tray delivery system poses a problem for residents. For example, an unserved resident may be observed trying to take food off another resident's tray or a resident may complain of being hungry and having to wait while a tablemate is already eating.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

When feeding a dependent resident is it required that the tray be placed in front of (within view) of them?

There is no written regulation that a tray be placed within view of a dependent resident during feeding. However, it is good practice and common courtesy to allow residents to enjoy the sense of sight and smell as well as their sense of taste during meals. The feeding process should facilitate the mechanics of chewing and swallowing and enhance meal consumption which does occur when the tray is placed in front of the resident. The feeding process also needs to normalize the meal experience as much as practicable to ensure that the resident's rights and dignity are protected. The feeding process should be tailored to the specific needs, desires, and physical condition of each resident and be addressed in the resident's care plan.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

Tube fed patients have a set number of cc intake ordered by the physician. In recording 24 hour intake on I&O records, a variance frequently appears. What is an acceptable variance? Example: 100 cc off in 24 hours on an order of 1800 cc of formula and 500 cc of water.

According to Interpretive Guidelines F300, 42 CFR §483.25(k)(2), "...(Allow flexibility up to 150 cc unless an exact fluid intake is critical for this resident)". This variance is for a 24- hour period.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

Is the following procedure acceptable for obtaining food temperatures upon patient receipt? Equipment - food thermometer (that has been cleaned with soap and water) and napkin/paper towel. Upon facility staff serving and setting up the tray for the patient, ask the patient for permission to take food temperatures. With the patient's permission check each food item, wiping the thermometer completely clean with the napkin/paper towel between food items. After the needle ceases to move record the temperature. After obtaining the temperatures wash the thermometer with soap and water, rinse well and dry.

Food temperatures upon patient receipt should be taken from a sample tray. If there is a special case in which a patient's tray is used to test food temperatures, the procedure listed above is acceptable. The thermometer needs to be cleaned once. If this thermometer is used for any application other than taking food temperatures upon patient receipt, the thermometer needs to be cleaned as stated above before putting it in a resident's food.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

What is adequate fluid intake for patients on Intake and Output?

Adequate fluid intake is dependent upon the individual patient's medical condition. The physician, nursing and dietary should perform assessments of the individual's need for fluid. The intake amounts must always be large enough to provide adequate hydration.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

How much time is acceptable between the serving of meals and the feeding of a patient? Is the critical point the time in which the feeding begins or when the patient finishes the meal?

There is not a specific time requirement in this area. Two related regulatory requirements must be considered and adhered to: proper food temperatures must be maintained, and no more than 14 hours may elapse between the evening meal and breakfast.

No regulations specify a maximum amount of time in which patients are to complete a meal. Some patients choose to eat at a slow pace, and have the right to do so.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

When serving trays in a room, is it permissible to give a tray to the self-feeding roommate before giving a tray to the roommate who needs assistance with eating in order to allow the self-feeding roommate to begin to eat as soon as possible? Would it make any difference if the privacy curtain were drawn?

With the following qualification, it is permissible to give a tray to the self-feeding roommate first. The qualification is that serving trays in this way should not be considered a problem by the roommates themselves. If both residents are alert and oriented, the reasons for serving the trays in this way should be explained to the roommates, including the fact that it is a requirement that proper food temperatures be properly maintained. They should be asked individually if they would consider this to be a problem, and whether they would prefer that the privacy curtain be drawn. If there is disagreement, staff should make every attempt to resolve it, and to tailor a solution to the particular situation. If one or both residents are not oriented and discussion is impossible, the trays may be served at different times. In such a case, staff should attempt to determine whether the residents are more comfortable with the privacy curtain drawn or not and act accordingly.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

If a tube fed patient is not receiving the amount of fluid recommended by a dietitian (as derived by an enteral nutritional assessment), what action should the surveyor take?

Failure to follow a dietary consultant's recommendation is not in and of itself a basis for citation. However in response to the example submitted a citation would occur if the surveyor determined upon review of the medical record and staff interview that one or more of the following had occurred:

(1) There was no documented evidence that the recommendation by the dietitian was communicated to the physician and there was no system in place to ensure effective communication.

(2) A physician's order had been received as a result of the recommendation but had not been carried out.

(3) The frequency and severity of the identified situation(s) indicated that the patient's need had not been met.

(4) There was no documented evidence of follow-up patient assessment should the physician elect not to accept the recommendation.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

Note: Replaces page 15 in Dietary section due to corrected answer.

What are proper food service temperatures to prevent food-borne illnesses?

The Food and Drug Administration instructions to surveyors found on form HCFA-804 and Licensure Rule .2701(h) state, "Hot foods shall leave the kitchen (or steam table) above 140 degrees F; and cold foods below 41 degrees F; and freezer temperatures at 0 degrees F or below."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

Are there guidelines for cold food storage?

Yes. The Interpretive Guidelines for F371 42 CFR §483.35(h)(2) state that potentially hazardous foods should be stored at 41 degrees F or below and frozen foods kept at 0 degrees F or below. The 1993 FDA Food Code provides guidelines for cold food storage.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

If a patient's diet is mechanically altered (pureed-chopped) and tolerated well would you mark chewing or swallowing problem L1 on the MDS?

Yes, if the diet was altered for chewing and swallowing problems. The type of diet a resident is on does not determine whether or not there is a chewing or swallowing problem. The resident assessment instrument (RAI) defines a chewing problem as "the inability to chew food easily and without pain or difficulties, regardless of cause." A swallowing problem for example "may include frequent choking or coughing when eating or drinking, holding food in mouth for prolonged periods of time, or excessive drooling."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

What are the qualifications for a facility's food service supervisor?

Licensure rule .2701(b) states: "The facility shall designate a person to be known as the director of food service who shall be responsible for the facility's dietetic service and for supervision of dietetic service personnel. If this person is not a dietitian, he or she shall meet the criteria for membership in the Dietary Managers Association which is hereby incorporated by reference including subsequent amendments and editions. Copies of criteria may be obtained from the Dietary Managers Association, 1 Pierce Place, Suite 1220 West, Itasca, Illinois, 60143 at no cost. If the course has not been completed, this person shall be enrolled in a course and making satisfactory progress for completion within the time limit specified by course requirements."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary
DATE: October 1996

Considering the exorbitant award to the victim of a hot coffee incident at McDonald's, what is the position on the serving temperature of hot liquids to our frail residents? The agility of our residents certainly should not be as great as someone in the drive through. Should we post a disclaimer "Hot foods served hot?"

No. It is not necessary to post a warning that hot foods, including hot liquids, are served hot. Food must be prepared and served in accordance with principles of sanitation and resident's rights related to food service. Both the licensure rules and federal regulations require food to be served at the preferred temperatures as discerned by the resident and customary practice (Licensure rule .2701(h) and federal regulation 42 CFR §483.35(d)(2), Tag F364). In addition, the licensure rule cited requires food to be served in a form to meet the patient's individual needs and with assistive devices as dictated by the patient's needs.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary
DATE: October 1996

Weight fluctuations - must a facility notify the physician when an obese patient loses five pounds?

A facility should follow its own policy regarding notification of MD of weight changes. The interpretive guidelines for F274 42 CFR §483.20(b)(4) "significant change in condition" define as a part of a decline - emergence of an unplanned weight loss (5% change in 30 days or 10% change in 180 days.) Please also refer to the interpretive guidelines for F325 and F326 42 CFR §483.25.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary
DATE: July 1997

Can non-perishable (not requiring refrigeration) cans of supplements that are unopened be returned to storage in the dietary department, i.e. shelved or refrigerator storage?

Unless the manufacturer's directions prohibit re-refrigeration, unopened non-perishable cans may be returned to storage from resident areas.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary
DATE: January 1998

Are nursing facilities that provide food to visiting family members required to be permitted as restaurants?

No. See attached letter from the N.C. Department of Environment and Natural Resources.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary
DATE: June 1999

Do you need a doctor's order to give dietary supplements to a resident who is on a regular diet?

There is no regulatory requirement for a physician's order for dietary supplements to be added to a regular diet. This practice is dependent upon facility policy and attending physician's preference.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

Is it acceptable for facilities to conduct cookouts and serve grilled foods to residents, family members, and staff?

Yes, providing the food is stored, prepared, distributed and served under sanitary conditions.

ENVIRONMENTAL

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental

Life Safety Code requires halls to be free and clear of all obstacles. What if a chair is placed in the hall during the ambulation of a patient who can walk only 50 feet and needs the chair to rest before continuing to walk again?

The situation described would not be a problem. Life Safety rules and regulations apply to equipment that has been stored (not in use) in the halls. As with any other item, such as laundry carts, food carts, patient care equipment, etc., items in use are not considered as relating to the rule mentioned.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental

What diagrams for circuit breakers are required at the electrical panel?

The National Electric Code requires a legible directory at the electrical panel. A legible handwritten directory is acceptable; however, if an illegible diagram/directory is found to be a repeat deficiency, a typed directory has been required in the past in order to solve the problem.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental

Is the use of a three-way adapter in a resident's electrical outlet against safety and fire regulations?

Yes, as a general rule. There may be exceptions.

Some three-way adapters are listed for the appropriate electrical load that one may wish to connect; however, you must not connect more electrical load to the adapter than it is listed for. A grounding type adapter would be required to be used in a health care setting if allowed by the fire official under section 704 of the North Carolina Fire Prevention Code and the device complies with the National Electrical Code. Generally the National Electrical Code would allow a grounded adapter in a health care facility if the adapter were listed by an agency such as the Underwriter's Laboratory (UL) and if the device is only used with a total connected load that does not exceed the adapter's amperage or wattage rating. A new provision of the 1993 National Electrical Code mandates that all new or replaced receptacles must be "hospital grade" listed at this time.

This would have to be evaluated on a case by case basis as determined by the DFS inspector, the local fire official and/or the local electrical inspector based upon the device, the connected load, and the specific use intended.

It is best not to use these devices because the tendency is to overload them and overloading may cause a fire. These devices may not provide the solid electrical connection needed to prevent shock hazards for the resident.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental

When stripping and waxing floors as is done annually, where can we put the furniture from the floors while we are working in the rooms? How can the resident's privacy be assured during this period?

Furniture cannot be left unattended in any corridor that is a path to an exit. Residents who are partially or completely confined to their beds may be moved to areas which provide for privacy (such as a solarium) or privacy screens may be employed.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental

What are the requirements regarding heat detectors in patient room closets of nursing homes?

One condition requiring such installation is in a facility certified for Medicare/Medicaid which, because of construction type, requires complete sprinkler coverage. The facility is required to meet the Life Safety Code which cites NFPA 13 for installation of sprinkler systems. NFPA 13 requires the installation of sprinkler heads in all spaces, including closets. If such a facility was built without total sprinkler coverage, it may be able to meet the Life Safety Code by waiver of the sprinkler system. Fire Safety Survey Report 1985 Code-Health Care (HCFA 2786P) requires in Part III, copy attached, at tag K81, the installation of automatic fire detection devices (heat detectors) in all areas required by the Life Safety Code to be protected by an automatic sprinkler system. Compliance with tags K80 through K83 are required before a waiver of the sprinkler requirement can be granted.

Part III Alternative Provisions for Sprinkler Requirements

If K56 on sprinkler coverage has been answered "NOT MET" and the facility is a one-story protected wood frame or one-story protected ordinary facility, answer the next four items.

K80 Hazardous Areas - All hazardous areas are sprinklered.

K81 Detection Systems - Automatic fire detection devices are installed in all areas required by the Life Safety Code to be protected by an automatic sprinkler system. The detection system is currently listed with UL's Fire Protection List. The system is arranged to close all fire doors in barrier partitions and where possible, shall be connected to the local fire department or central control station. At a minimum, the detection system must activate an alarm system inside and outside the building.

K82 Compartmentation - Patient rooms are separated from each other and all other areas by construction having at least 1 hour fire resistance rating.

K83 Fire Department Response - The response time and capability of the local fire department is adequate, in the judgment of the State fire authority official, to provide an acceptable level of protection for an unsprinklered facility.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental

Is the facility required to post "No Smoking, Oxygen in Use" signs on resident doors when the facility is a smoke free facility that has a sign at the front entrance requesting that all smoking materials be extinguished before entering the facility?

Yes.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental

May housekeeping duties be performed on the nursing units while meal trays are being served?

Yes, as long as no contamination of food occurs and there is no disruption to the areas in which patients are actually eating.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental

What is a Fire Safety Evaluation System (FSES)? May it be substituted for compliance with the Life Safety code (LSC) in life safety surveys?

Federal regulations require facilities to be in compliance with the Life Safety Code (LSC), which sets federal fire protection standards. Generally, a facility may meet this requirement either by complying with the requirements of the edition of the LSC applicable to the facility or by achieving a passing score on an equivalency instrument known as the Fire Safety Evaluation System (FSES). The FSES is designed to assess whether or not a facility's existing life safety features protect occupants of the facility in a manner equivalent to meeting the literal requirements of the LSC. An FSES evaluation assigns numerical values to specific building and operating features such as sprinklers, exit distances, building height, age of occupants, ability of occupants to evacuate, patient/staff ratios, etc. Then, the FSES uses a mathematical formula similar to a grading system to determine if a building, while not meeting every LSC requirement, has the equivalent safety of a building that does meet all the requirements of the LSC.

If a facility is cited for a life safety deficiency under the LSC, the facility must submit a plan of correction. When submitting its plan of correction, the facility may request an evaluation under FSES. A facility that is evaluated under FSES may have to add to or correct certain features of the building or staffing arrangements to attain a passing score. Sometimes, equivalent safety cannot be attained without repairs or additional features that would cost virtually the same as compliance with the LSC. If the facility elects to be in compliance using FSES, it may have to revise its plan of correction to accommodate the changes needed to achieve passing scores on the FSES and/or correct those deficiencies that are not within the scope of the FSES.

Actual compliance with the LSC may be preferable to compliance using FSES because a facility operating under FSES compliance is more likely to be out of compliance if there is a change in FSES evaluation factors, e.g. staffing or changes in patient population, than a facility in compliance with the LSC.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental

What should water temperatures be in patient care areas?

Licensure rule .3404(d) states, “A flow of hot water shall be within safety ranges specified as follows:

> Patient Areas - 6 1/2 gallons per hour per bed and at a temperature of 100 - 116 degrees F.”

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental

What are the proper laundry and dietary water temperatures?

Licensure rule .3404(d) states, “A flow of hot water shall be within safety ranges specified as follows:

> Dietary Services - 4 gallons per hour per bed and at a minimum temperature of 140 degrees F, and
>
> Laundry Area - 4 1/2 gallons per hour per bed and at a minimum temperature of 140 degrees F”.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental
DATE: October 1996

Can air filter machines be utilized in a resident's room?

Yes, if:

1. The machine has no built-in electric heat.

2. The building electrical system has sufficient capacity to safely power the unit(s).

3. The unit is listed and maintained in accordance with the requirements of a nationally recognized test lab such as U.L. or ETL.

4. The unit is arranged so as not to produce a trip hazard from the cord.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental
DATE: October 1996

Can aerosol spray cans be used and stored in residents' rooms, i.e. hair sprays, Lysol and deodorant? These would have the resident's name and room number on them.

Federal regulations found at tag number 323 address storage of cleaning supplies. Regulations do not address personal care items, but safety must be a priority consideration.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental
DATE: October 1996

What are the regulations pertaining to cubicle curtains re: 1) replacement requirements; 2) diameter (gauge) of mesh openings; and 3) distance of curtain from sprinkler head?

The LSC interpretive guidelines indicate that nursing facilities should all have cubicle curtains with 1/2 inch mesh by November, 1996. If facilities do not have 1/2 inch mesh or greater, they can rehang cubicle curtains to the distances specified in NFPA-13, Table 4-2.5.2 (attached).

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental
DATE: October 1996

Can housekeeping or laundry carts be stored on the floor during meal delivery and feeding?

No. Carts can only be on the halls when in actual use. Carts cannot be stored in the halls.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental
DATE: September 1997

What is the acceptable practice for surveyors to take temperatures (food, water, room, etc.), specifically using their thermometer, the facility's or both?

Water temperature should be taken with a glass bulb thermometer of scientific quality. Food temperature should be taken with a quality meat thermometer. The thermometer may belong to either the facility or surveyor.

How does the facility know the surveyor's thermometer is calibrated correctly, etc.?

The surveyor will allow facility staff to compare the facility thermometer to the surveyor thermometer at the same test location. Calibration can be checked by using an insulated cup with crushed ice/water swirled around for two minutes. The thermometer should read 32 degrees F in this solution.

Should the surveyor take the temperatures in the presence of a staff member?

Yes.

How is a room temperature taken?

Room temperature is taken with a sling psychrometer which has two glass bulb, mercury filled thermometers that are twirled in the air for two minutes.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental

Is there guidance available concerning items and materials that are proper for residents to keep in their room versus those that are inappropriate? Are there regulations that dictate if the following items can or cannot be kept in a resident's room?

- Medications:
  - Aspirin, Anacin, Bufferin, Tylenol, Advil, Nuprin, or other pain relief products
  - Mentholatum, Vicks, Deep Heat, Ben-Gay, Flex-All or other arthritic rubs
  - Vaseline, Olive Oil or Castor Oil
  - Sinus Medication – Sinutab, ChlorTrimeton, Sudafed or other antihistamines
  - Cough syrup, Drops or cold Medicines – Robitussin, Nyquil, Contact, etc.
  - Rubbing Alcohol or any liniments
  - Ex-Lax or any laxative
  - Vitamins
  - Eye Medications, Visine, Clear Eye's, etc.
  - Anti-acids, Maalox, Mylanta, Gaviscon, Pepto-Bismol, etc.
  - Sleeping Pills – Sominex, Nytol, etc.
  - Foot Powders or Creams – Desenex, etc.
  - Hemorrhoid Treatment creams or pads – Preparation H, etc.
  - Noxzema or any medicated creams or powders

- Household items:
  - Aerosol Cans – combustible products, Glass items, Razors with loose blades
  - Scissors and Knives, Smoking materials - matches, lighters, etc.
  - Plant Food, Cleaning Supplies, Wine or other Alcoholic beverages
  - Hot or Cold packs, Scatter rugs, extension cords
  - Electrical appliances – coffee pots, toasters, electric blankets, curling irons, iron, space heater, etc.
  - Christmas lights

Yes. There are multiple health regulations that address materials that residents can keep in their rooms. Life Safety Code and fire standards have specific guidance regarding electrical equipment, extension cords, etc. that may or may not be allowed. A facility should check with the Construction Section regarding the use of appliances, space heaters, extension cords, etc. before using.

Following is a list of federal and state rules addressing the two areas: medications and household items.

Medications

Federal Requirements

F176 483.10(n)
F425 483.60(a)
F431 483.60(d)
F432 483.60(e)

State Rules

10A NCAC 13D .2306
10A NCAC 13D .2604
10A NCAC 13D .2605

Household Items

Federal

No Prefix	483.10(l)
F252	483.15(h)(1)
F253	483.15(h)(2)
F323	483.25(h)(1)&(2)
F454	483.70
F465	483.70(h)

State Rule
10A NCAC 13D .3400

State Statute
131E-117(14)

The above list is not all inclusive of the regulations and rules but should provide guidance to facilities in evaluating what kinds of medications and household items should or should not be kept in a resident's room and under what conditions they should be kept in a resident's room. Assessment and care planning are an important part in determining the utilization of these items. Also, the resident population of the facility and/or unit population is important in making determinations about the use of these items.

INFECTION CONTROL

INFECTION CONTROL

INFECTION CONTROL

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

If a resident wets or bleeds on clothing does that clothing have to go in a biohazard labeled barrel and be bleached or can it go back to a residential clothing barrel?

The OSHA bloodborne pathogens standard at section 1910.1030 states that contaminated laundry must be placed and transported in bags or containers that are color coded or labeled with the biohazard label. Contaminated laundry is defined as laundry which has been soiled with blood or other potentially infectious materials or may contain sharps. "Other potentially infectious materials" besides blood include semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid which in situations where it is difficult or impossible to differentiate between body fluids. Therefore, clothing stained with blood should be treated as contaminated.

Note that urine is not included on the list of other potentially infectious materials. Therefore, there is no requirement that clothing soaked with urine alone be treated as contaminated laundry. However, urine may be a potentially infectious material if mixed with other body fluids in situations where the facility cannot tell if the other fluids are on the potentially infectious list.

Note that many facilities have elected to treat all body fluids as potentially infectious, although this is not required under the OSHA standard. The OSHA standard does provide, however, if the facility elects to treat all body fluids as infectious, and to use standard precautions regarding all body fluids, the facility may use alternative labeling or color-coding, instead of that prescribed in the OSHA standard, so long as the alternative allows employees to recognize the containers as requiring compliance with standard precautions. Bleach is not necessary if acceptable laundry procedures are used.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

May Aqeous Zephiran be used to clean thermometers?

Zephiran and/or hydrogen peroxide are not recommended to be used to clean thermometers. It is recommended to do the following when cleaning thermometers:

- Rinse and clean thermometers with soap and water
- Disinfect for 20 minutes in 70% alcohol
- Dry and store

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Do male patients have to keep the lids on their urinals when not in use?

Aesthetically, lids on urinals should be kept in place when not in use. Absence of lids alone, however, would not justify a citation.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Can personal care items be stored on the sink area? Private room? Semi-private room? What if each side of the sink area is designated to beds, e.g. the right side of the sink is for bed A and the left side is for be B?

Yes. In a semi-private room personal care items should be labeled, if grouped. Items may be stored in the same location in the bathroom as long as storage areas are clean and are consistent with appropriate infection control practices.

REGULATORY FOCUS BULLETIN

NOTE: "FYI is an informational and educational service of the Regulatory Focus Committee to assist you in finding the resources for answers to questions regarding issues not regulated by the Division of Facility Services. The source of the information is included for your reference

FILE TOPIC: Infection Control

Is the protocol for dressing a clean wound different from the protocol for dressing an infected wound? If so, what is the difference?

No. The principles for aseptic technique are the same for both situations and call for preventing contamination of clean areas (or equipment).

Reference:

"Guideline for Hand Hygiene in Health-Care Settings, 2002", Centers for Disease Control, U.S. Department of Health and Human Services, Atlanta, Georgia.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

When can disposable wipe be used inlieu of handwashing with soap and water? What types of wipes or preparations are acceptable?

The Guideline for Hand Hygiene in Health-Care Settings was published in the Morbidity and Mortality Weekly Report on October 25, 2002. Hand Hygiene has replaced handwashing as the standard for patient care and is referred to as decontamination. Antimicrobial-impregnated wipes (i.e. towelettes with alcohol) may be considered as an alternative to washing hands with non-antimicrobial soap and water. Because they are not as effective as alcohol based hand rubs or washing hands with an antimicrobial soap and water for reducing counts on the hands of Health Care Workers, they are NOT a substitute for using an alcohol-based hand rub or antimicrobial soap. In terms of what is acceptable for selection of hand hygiene products the CDC states alcohol-based hand rubs are the most efficacious agents for reducing the number of bacteria on the hands. Antiseptic soaps and detergents are the next most effective, and non-antimicrobial soaps are the least effective. Soap and water are recommended for visibly soiled hands. Alcohol-based hand rubs are recommended for routine decontamination of hands for all clinical indications (except when hands are visibly soiled). Wipes (of any kind) are ok, only if followed by alcohol-based hand rubs (containing 60%-95% ethanol or isopropanol) for decontamination.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Can egg crates be washed and reused if they are returned to the same resident?

Yes, if the manufacturer's directions are followed. Flame retardation properties may be reduced by washing.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Describe the appropriate protocol for the use of scissors between "clean" dressing changes.

Scissors should be cleaned with an appropriate agent (for example, alcohol) before each resident's use and between removal of an old dressing and application of a "clean" dressing.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

There are incidents in other states where facilities are being cited (under OBRA) for not having all items covered on the food tray (including dessert or bread) during the transport of the tray from the food cart to the patient. Is this appropriate? Will this be done in North Carolina?

If food carts are covered and positioned outside the resident's room and the tray is removed and taken directly into the resident's room, covering the dessert, breads and beverages is not required.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Can alcohol gel pumps be left on top of the med cart during med pass?
The patient's room?

Yes

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Page Reserved

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Can a facility use styrofoam water pitchers instead of plastic and rather than sanitizing the styrofoam pitchers on a routine basis just discard them?

Yes. However, due to the porous nature of styrofoam, some type of plastic liner should be used. If this liner is the rigid construction type it should be sanitized on a routine basis.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

If a resident in a semi-private room has a culture positive for methicillin-resistant staph aureus (or any other highly resistant organism) would there be a violation of resident's rights to request a resident in a private room to move to a semi-private room so the private room could be used for an isolation area?

Are there factors that could otherwise influence this move such as payment source, resident/family disagreement with the move, which resident in private room to first consider for the move, privately owned facilities with only a few private rooms (less than 10) used only for private-pay residents? Should they be required to provide the same option rather than an acute care admission?

Licensure rule 10 NCAC 3H .2209(a)(b) states, "The facility shall establish and maintain an infection control program for the purpose of providing a safe, clean and comfortable environment and preventing the transmission of diseases and infection. Under the infection control program, the facility shall decide what procedures, such as isolation techniques, are needed for individual patients, investigate episodes of infection and attempt to control and prevent infections in the facility." It is presumed that each facility has a room or rooms identified for isolation should there be such a need. Patients should be advised at the time of admission that certain types of infections necessitate isolation precautions requiring a private room (or single patient use of a semi-private room) and that a room transfer might be needed under those circumstances. If the above has taken place then there is no violation of resident's rights (either the infected patient, the patient in a private room, or the roommate of an infected patient).

Federal regulation 42 CFR §483.12 indicates that a patient cannot be transferred or discharged (includes intra-facility transfers) unless...(iv) the health of individuals in the facility would otherwise be endangered. If "endangered" is interpreted to include increased risk of infection (roommates) or increased compromise of a debilitated individual with an infection, then a room transfer may be acceptable with proper documentation and notification of the patient/family/legal representative.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

What is the rule for posting signs when a resident is using an O_2 concentrator? This is not currently addressed in regulations - only when oxygen tanks are in storage or use.

"O_2 in Use" and "No Smoking" signs should be posted with O_2 concentrators as with O_2 cylinders.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

When measuring output in urinary drainage bags, can one calibrated cup be rinsed and reused to measure output for more than one resident if appropriate technique is used?

No. When emptying catheter bags, use a separate container for each patient and do not let the drain spigot of the bag touch the sides or opening of the container. The container must be rinsed after each use and may be reused throughout the resident's stay in the facility. This practice is in accordance with Centers for Disease Control (CDC) guidelines for the prevention of urinary tract infections.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

During medication administration, some handling of medications may be necessary (e.g., breaking tablets, emptying capsules). Are gloves necessary or are clean hands adequate?

Gloves are not necessary. Clean hands are all that is required.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

When should handwashing take place during a medication pass?

Hands should always be decontaminated before and after coming in contact with saliva and other body fluids, administering eye drops and injections, applying patches (e.g., Nitro), and all tube feedings (gastrostomy, nasogastric).

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

What can be used in oxygen humidifiers? Distilled water? Sterile water?

According to the Centers for Disease Control, sterile water is to be used in oxygen humidifiers.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Can a nurse aide leave incontinent pads or other linen supplies she intends to use during that shift for a particular patient in that patient's room?

Yes. Small amounts of linen supplies may be left in a patient's room. These supplies, once left in the room, may only be used for that patient, and supplies are not to be "stockpiled".

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Can clean linen be carried into and out of a patient's room and into another?

There is no prohibition against distributing linen to more than one room at a time. Infection control practices must be observed, and care should be taken that the linen is not contaminated while in the first room.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Page Reserved

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Clarify items which should not be discarded in patient trash cans.

To insure a safe environment and prevent the spread of infections, items soiled with bodily fluids such as blood, urine, or drainage from wounds should not be discarded in trash cans in patient rooms. This includes soiled gloves, incontinent pads, diapers and supplies used in the treatment of draining wounds. Transdermal nitroglycerin patches should not be disposed of in patient trash cans.

In an effort to control insects and rodents, patient care items such as tube feeding supplies and foley catheters should not be discarded in patient trash cans. Medicine cups and plastic drinking cups may be discarded in patient trash cans. Significant amounts of medications left in cups should be considered a medication administration issue.

Trash cans should be emptied at least daily or more frequently as needed.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Recapping needles.

State law (90.113.4A) and Centers for Disease Control guidelines state that needles shall not be recapped, purposely bent, clipped or broken by hand. They shall be placed in a hardwalled container immediately after use and disposed of in a sanitary landfill or placed in an incinerator. CDC guidelines recommend that containers be located where needles and syringes are used and that needles and syringes should be placed intact directly into these containers. A hardwalled container on the med cart is adequate, except in those circumstances where a med cart is not taken to the patient's room. When a single injection is to be administered and a med cart is not taken to the patient's room, the nurse administering the injection should carry a hardwalled container to the patient's room.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Please clarify conditions under which treatment carts may be taken into patient rooms.

There is no restriction on taking treatment carts into patient rooms, as long as nursing staff do not contaminate the cart while it is in the room. [Examples: placing dirty dressings on the cart, going back and forth to cart with contaminated hands, or placing supplies and equipment on the patient's bed then returning them to the cart.] The cart should be secured while in the room so as not to be accessible to other patients in the room. If left in the hallway the cart should be secured so that no medications or biologicals are accessible to patients.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Can a facility be cited for not zipping up the linen covers on linen carts while they are in use?

There is no regulation requiring zippers on linen covers. Linen, however, should be covered. Federal regulation 42 CFR §483.65(c) states, "Personnel must handle, store, process and transport linens so as to prevent the spread of infection." Therefore, an unzipped linen cover would not in and of itself constitute a deficiency.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

For routine suctioning (no isolation) must you either use disposable canister liners or gown-mask and gloves?

No.

Can facilities continue to use the suction machines with glass bottles using facility disinfection policies?

Yes.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

When residents have extended length oxygen tubing is it permissible that it touch the floor? This is in reference to residents who freely ambulate in their room and need longer tubing. The facility has a policy for wiping down the tubing and changing it weekly. The actual short cannula and nose prongs do not touch the floor. Covers that the facility has made to slip the tubing through were refused by one resident who stated that it made the tubing heavy. Some residents must have the longer tubing to allow them freedom to ambulate and it is impractical to think the tubing won't touch the floor. The floor is cleaned daily. The tubing is a closed system.

For those residents who need extended length tubing in order to ambulate freely in their room or the facility, it is permissible for the extended length tubing to come in contact with the floor. It is not permissible for the cannula or mask to touch the floor.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Do bedpans and urinals have to be labeled/dated?

Dating is not required. Bedpans and urinals should be labeled with the patient's name when used/stored in an area considered multi-use, e.g., residents in semi-private or ward accommodations.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Can a facility be cited in a situation where a nurse aide is feeding residents at a feeding table and does not wash her hands between the feeding of each resident, if she has not touched a resident?

No. There is no cross contamination from one resident to another if there is not direct contact.

Reviewed and Revised
01/03

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Can cloth towels/washcloths be kept on towel racks in dual-use bathrooms?

Yes, as long as they are not soiled.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

When a nurse is doing a dressing change, she dons gloves, removes the soiled dressing, disposes of the dressing and the dirty gloves, then regloves to apply the clean dressing. This procedure was recently cited for poor infection control because the nurse did not wash her hands after she removed the dirty gloves. Would you describe the correct procedure? (During surgery, the operating team does not rescrub during the operation if
a glove change is indicated.)

No. There is no definitive information available to support washing hands between glove changes when doing a dressing change involving one resident.

The reference is the U.S. Department. of Health and Human Service Clinical Practice Guidelines for the Treatment of Pressure Ulcers Dec. 1994. In that guideline, expert opinions given by numerous well-known clinicians and researchers state, "one set of gloves can be used on the same patient with multiple pressure ulcers". Hands washed and gloves changed between patients. It also states that clean gloves are acceptable as has been the standard in North Carolina Long Term Care Facilities. The guideline also recommends when treating multiple ulcers on the same resident to treat the most contaminated ulcer last (i.e.. the perianal region). Then remove gloves when the entire dressing care is completed and wash (decontaminate) hands between patients.

Therefore, the sequence is the nurse removes the dressing with clean gloves, then redresses the wound using the same set of clean gloves. If a resident has multiple ulcers, the nurse must assess the least contaminated site and change the dressing with one set of gloves going from the least to most contaminated site. Should the nurse need to remove gloves because the gloves are rendered non intact, then the current CDC Hand Hygiene should be followed to decontaminate the hands prior to new gloves being donned. Should the nurse choose to remove visibly intact gloves after removing the dirty dressing the nurse may don new clean gloves and continue the wound care.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

How long can tube feedings hang, and how often do the bags and tubing need to be changed?

There are numerous types of products being used in health care facilities that have varying safe hang times. Follow the recommendation of the manufacturer regarding the particular product in use.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

How long can normal saline be used after it has been opened?

If the solution is being used to irrigate foley catheters, for bladder irrigations or during sterile treatments such as a sterile dressing change, the solution is only good at the time of opening. Any solution left after these procedures must be discarded.

When the solution is being used for non-sterile procedures such as clean dressing changes, the facility may use its own discretion to determine policy regarding frequency of discard. Although in acute care the standard is to discard after 24 hours, it has been acceptable practice in long term care to discard after 30 days. It is recommended that the facility policy indicate use of the solution not to exceed 30 days after opening. Facilities should consider using smaller bottles in some situations to prevent waste.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

The Centers for Disease Control have clearly mandated the use of sterile water where aerosolization does not take place when "tank" or "concentrator" oxygen is passed through a bubble type humidifier at flow rates of less than 3 liters per minute. I would like clarification on this issue. Also clarify the frequency with which water must be changed.

(1) The use of humidification with oxygen flow of less than 3 liters/minute is not necessary and should be discouraged. (Could possibly be another source of infection).

(2) Pre-filled humidifiers: Follow manufacturer's guidelines for replacement and disposal.

(3) Disposable humidifiers: Sterile water must be used; replace unit at least every 72 hours.

REGULATORY FOCUS BULLETIN
FOR YOUR INFORMATION

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CDC National AIDS Hotline: 800-342-2437 (800-342-AIDS). Open 24 hours a day, this is an education, information, and referral service. They are able to provide on-line information about AIDS and HIV infection topics such as transmission and testing. Names of organizations for counseling and practical support are available, as is referral to testing sites and physicians. This hotline is also able to provide names of long-term care facilities across the nation that admit people with HIV infection and AIDS.

CDC National Spanish-speaking AIDS(SIDA) Hotline: 800-344-7432 (800-344-SIDA). Open daily from 8:00 am to 2:00 pm EST, this line provides information in Spanish.

CDC National Hearing Impaired (TTY/TDD) AIDS Hotline: 800-243-7889 (800-AIDS-TIY). Open weekdays from 10:00 am to 10 pm EST, this hotline is for use by the hearing impaired.

CDC National AIDS Clearinghouse: 800-458-5231. The Clearinghouse is a comprehensive information service for people working in HIV and AIDS including public health professionals, educators, social service workers, attorneys, human resource managers, and employers. The Clearinghouse collects, classifies, and distributes up-to-date information and provides expert assistance to HIV and AIDS-prevention professionals. This number is available from 9:00 am to 7:00 pm EST Monday through Friday except government holidays, and it is accessible by either touch-tone or rotary-dial telephones. The specialists there will answer inquiries, make referrals, and help locate publications pertaining to HIV infection and AIDS.

You can obtain materials from the Clearinghouse that can help keep you up-to-date with scientific findings, clinical trials, workplace and business information, CDC guidelines, and changing trends of the HIV epidemic. Copies of selected reprints from CDC's MMWR and HIV/AIDS Surveillance report and other educational materials are available. You may obtain free brochures and posters, and low-cost videotapes for use in HIV prevention activities. Some of these materials are available in Spanish. A nominal prepayment is required for postage and handling costs when bulk quantities of materials are ordered.

REGULATORY FOCUS BULLETIN
FOR YOUR INFORMATION

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Obtaining Information From CDC By Telephone

Have you ever wanted to call CDC for help with a problem or information about a specific infectious disease but hesitated to go to the trouble? Although CDC does have hundreds of telephone numbers and extensions, there are a few that are especially helpful to infection control practitioners.

Public Inquiries: 404-639-3534. If you are not sure what type of information you need, this number is a good place to start. The operator at this number can direct your inquiry to the proper channel.

Voice Information System: 404-639-3406. This number provides recorded messages about various diseases, health information for international travelers, and the MMWR. To use this service, you must be calling from a touch-tone telephone. For first time callers, there is a special message on how to use the system. The information is prepared by CDC professionals, and it is updated as needed. There is no operator assistance, but most selections allow for transfer to CDC professionals for additional help. Many of the messages can be repeated, if you want to hear one a second time.

At this time, the voice information number includes messages and information about HIV infection and AIDS, hospital infections, influenza, Lyme disease, hepatitis, foodborne bacterial disease, Rocky Mountain spotted fever, rabies, cytomegalovirus infections, Epstein-Barr infections, and others.

This service is available from 8:00 am to 4:30 pm EST, Monday through Friday, except on federal holidays.

REGULATORY FOCUS BULLETIN
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As of March 6, 1992, facilities are subject to OSHA standards under section 6(b) of the Occupational Safety and Health Act of 1970 29 U.S.C. 655 to eliminate or minimize occupational exposure to Hepatitis B Virus (HIV), Human Immune Deficiency Virus and other bloodborne pathogens. These regulations require a combination of engineering and work practice controls, personal protective clothing and equipment, training, medical surveillance, Hepatitis B vaccination, signs and labels, and other provisions such as the "Universal Precautions" established by the CDC. Using centrally located covered containers for potentially infective material is a recommended means for decreasing employee and resident exposure.

Publications from the Centers for Disease Control may be ordered from:

National Technical Information Services
US Department of Commerce
5285 Port Royal Road
Springfield, VA 22161
(703) 487-4650

Main Campus
US Dept. of Health and Human Services
Centers for Disease Control
Centers for Infectious Diseases
Atlanta, GA 30333
(404) 639-3311

REGULATORY FOCUS BULLETIN
FOR YOUR INFORMATION

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How often do you need to change the sterile trach care kit when cleaning an old trach? Do you have to use sterile or can it just be clean technique?

Clean technique is acceptable when cleaning an old trach, and the trach kit does not have to be discarded after each use if the following procedure is maintained:

1. The kit is used for the same patient;

2. The device must be cleaned and disinfected appropriately after each use:

    a) Cleaned with soap and water and rinsed well;
    b) Disinfected in a diluted bleach solution or alcohol for twenty minutes;
    c) Rinsed well;
    d) Air dried.

3. The kit should be replaced when there is evidence of the deterioration of the device (i.e., cracking or pitting).

Source: Karen Hoffman, Statewide Infection Control Network, UNC School of Medicine

REGULATORY FOCUS BULLETIN
FOR YOUR INFORMATION

NOTE: "FYI is an informational and educational service of the Regulatory Focus Committee to assist you in finding the resources for answers to questions regarding issues not regulated by the Division of Health Service Regulation. The source of the information is included for your reference.

FILE TOPIC: Infection Control
DATE: November 2003

What is the proper way to sanitize feeding syringes?

The NC Sanitation Rule 15A NCAC 18A .1318 addresses "feeding syringes." The rule specifically states, "Feeding syringes which are reused shall be labeled with the patient's name and date opened, shall be disassembled and rinsed after each use, and shall be disposed of within 24 hours of first use. Tube feeding bags shall be changed within the time period specified by the manufacturer. Oral suction catheters which are reused shall be flushed after each use and shall be disposed of within 24 hours of first use. Feeding syringes and oral suction catheters shall be stored in a clean container".

REGULATORY FOCUS BULLETIN
FOR YOUR INFORMATION

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FILE TOPIC: Infection Control

We were of the understanding that in nursing facilities, patients positive with MRSA, do not require private rooms. This has been communicated to us by Karen Hoffman, State Infection Control Officer and through articles written regarding guidelines for MRSA patients in nursing facilities. We are told that surveyors believe these patients must be in private rooms and if not, facilities are being cited. Please clarify.

The main infection control practice that should be routinely carried out in the long term care setting is hand washing between patient contacts. In addition, wound care using universal precautions with appropriate barrier precautions as outlined is necessary. In a non-outbreak setting in long term care facilities, surveillance cultures and attempts at decolonization should not be routinely performed. Until a safe and efficacious method of eliminating the carrier state is developed and shown to be followed by a decrease in MRSA infections, routine use of systemic antibiotics or local ointments is also discouraged.

Long term care facilities are unique in that patients are encouraged to join in group activities, participate in physical and occupational therapy, and eat in a common dining room. All of these maneuvers enhance the functional capability of the patients and are important in their rehabilitation. To isolate or cohort ambulatory patients with MRSA would be contrary to the philosophy and policy of most long term care facilities. Thus, unless an outbreak has occurred, the routine use of isolation and cohortation is not encouraged. The exceptions might be a cluster of bedbound nursing home patients with Foley catheter-associated MRSA urinary tract colonization, patients with wounds heavily colonized by MRSA, or patients with tracheostomies who are unable to handle secretions; these patients probably should be cohorted or placed into contact isolation until they have been cleared of MRSA.

Excerpt from: "Methicillin-Resistant Staphylococcal Colonization and Infection in a Long-Term Care Facility", American Journal of Medicine, Volume 94, March 1993

REGULATORY FOCUS BULLETIN
FOR YOUR INFORMATION

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FILE TOPIC: Infection Control

What is the proper infection control procedure for disposal of disposable diapers?

Disposable diapers fall into the category of solid waste. Solid waste is defined as material or objects (biological or non-biological) which are discarded and not intended for further use.

Proper disposal of disposable diapers would be in the regular waste unless it is contaminated with blood. According to CDC, feces and urine are specifically excluded from the universal precautions recommendations unless visible blood is present.

Non-infective disposal diapers can be handled through the regular trash system because it is not considered a public health hazard. For sanitary purposes, the disposable diapers should not be discarded in resident rooms nor in resident bathrooms.

As with all solid waste management, the disposable diapers should be transported and stored within the nursing home in cans or carts which are covered at all times. It should be taken to the outside waste disposal container via the most direct route to avoid all food preparation and serving areas.

The outside solid waste disposal containers are maintained and emptied in compliance with local city and/or county codes and regulations.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Do gloves have to be changed between wounds on the same patient?

No. The Clinical Practice Guidelines, Pressure Ulcer Treatment, U.S. Department of Health and Human Services state that, "Clean gloves; Use clean gloves for each patient. When treating multiple ulcers on the same patient, attend to the most contaminated ulcer last (e.g., in the perianal region). Remove gloves and decontaminate hands between patients."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

What is the proper procedure for the handling of soiled linen for a patient in isolation? We keep a hamper in the room, double bag at the end of the shift or as indicated. We were informed that soiled linen had to be removed from the room in approximately thirty minutes.

All soiled linen from all residents should be handled as if it were contaminated with pathogenic organisms, including bloodborne pathogens. When removing items from an isolation room, most articles do not need to be bagged unless they are contaminated with potentially infective material such as blood, bloody fluids, wound drainage or feces. Double bagging is no longer recommended or necessary unless the rare incident occurs where the outside of the bag is visibly soiled.

REGULATORY FOCUS BULLETIN
FOR YOUR INFORMATION

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FILE TOPIC: Infection Control

How often should disposable suction canisters for suction machines be changed in a long term care setting?

"Suction canisters collect, in general, secretions from the respiratory tract; and while these secretions may appear unsightly, while inside the canister they are a minimal risk of cross-transmission. The canister in use remains under negative pressure; therefore, the reservoir of potentially infectious material is contained. There are no CDC or other guideline references of which I am aware; therefore, I recommend the following in answer to your question:

Suction canisters may be emptied and reused until the patient no longer requires suction. The canister should be emptied into a clinical sink (hopper) or toilet. If a patient has an unusually long need for use of a suction canister or the canister remains visibly soiled after rinsing, a new canister should be issued."

Source: Statewide Infection Control Program, School of Medicine, Department of Medicine, Division of Infectious Diseases, University of North Carolina at Chapel Hill, Chapel Hill, NC.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control
DATE: September 1996

What if an employee cannot be Mantoux PPD skin tested, are there written requirements regarding chest x-rays? Is one negative chest x-ray enough for the duration of employment if no signs or symptoms of TB are noted?

The only time an employee does not need to be PPD skin-tested is when there is a verified (documented) prior positive skin test result. In this situation, if there is evidence of a negative follow-up chest x-ray, repeat chest x-rays are not indicated unless symptoms develop that could be attributable to TB. The annual screening procedure for persons with documented prior positive PPD results is a verbal elicitation of symptoms similar to the procedure found on DEHNR 3405 (Record of Tuberculosis Screening). This form is available through the county health department and can be adapted by the facility to reflect the appropriate letterhead. If the employee is "sensitive" to the PPD as evidenced by a significant localized reaction that does not include any induration, it may be appropriate to suggest the application of a topical cortisone-type ointment or an ice pack for relief of swelling or itching. For additional information contact your local county health department or call the NC TB Control Branch at 919/733-7286 or 733/1193.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

How long after being hired does a staff member have to have a TB test? If the test expires during employment, how much time do they have to get it up-to-date and can they work during this time?

Current State licensure rules specify that staff must be tested within seven days after being hired. TB screening should be repeated annually, and should be planned. If there are no signs or symptoms of active TB, there should be no reason (related to TB) why these persons should not work.

If a staff member provides documentation of a TB test, what is the length of time is which you can accept that test as test 1in the 2-step testing?

CDC guidelines recommend that the second TB skin test be done within one to three weeks after Step 1or the 2 Step procedures.

If a staff member has documentation of a chest x-ray, do we send them for another one or can we accept the documentation and have the staff member fill out a symptoms checklist?

Current CDC TB screening guidelines do not advocate the use of chest x-rays as a routine screening. A checklist regarding symptoms should be completed for those persons with a positive TB skin test.

If a staff member has had a check x-ray but cannot provide documentation, do we schedule another?

No. The staff member should be encouraged to provide documentation of the chest x-ray. A chest is not considered a routine TB screening tool. Therefore, a second chest x-ray should not be routinely scheduled. A checklist regarding symptoms should be completed.

Reviewed and Revised 12/04

REGULATORY FOCUS BULLETIN
FOR YOUR INFORMATION

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FILE TOPIC: Infection Control
DATE: July 1997

Do volunteers need a TB test?

Yes. CDC guidelines recommend that health care workers should be included in a TB screening and prevention program. This should include volunteers who are in contact with patients.

REGULATORY FOCUS BULLETIN
FOR YOUR INFORMATION

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FILE TOPIC: Infection Control
DATE: September 1997

On admission, a resident or family member as appropriate, has been informed of the risks and benefits of the flu vaccine. Is it necessary to provide the same information in the fall and each succeeding fall the resident remains in the facility?

Yes, because flu vaccines and health department recommendations may change every year. Federal regulation 42 CFR §483.10(d)(2) states, "The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being." The Interpretive Guidelines state, "Informed in advance means that the resident receives information necessary to make a health care decision, including information about his/her medical condition and changes in medical condition, about the benefits and reasonable risks of the treatment, and about reasonable available alternatives."

Some facilities also require agreement/consent annually for the administration of this vaccine. Is a written consent necessary?

Because it is necessary to explain the benefits and risks of the flu vaccine, the agreement/consent of the resident or family member is necessary. Whether the agreement/consent must be written is up to the facility.

A November 1996 issue of the Regulatory Focus Bulletin stated, "It is not necessary to fill out and have a physician sign a telephone order slip when standing orders are initiated per facility policy." Do standing orders to administer flu vaccine fall into this category?

No. Because the flu vaccine and the resident's condition change yearly, a new physician's order is necessary in order to comply with Licensure rule .2306(d)(1).

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control
DATE: January 1998

If a staff member says they have a positive TB test but cannot provide documentation, do we repeat the test or schedule a chest x-ray?

If documentation of a previous positive TB skin test cannot be provided, a TB skin test or TB screening should be performed under the direction of the medical director or employee's physician.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control
DATE: June 1999

Is the facility required to monitor the temperature on a daily basis for individual personal refrigerators that are located in a resident's room?

No. There is no regulatory requirement.

Is the facility required to date and label food that is brought by family members and stored in an individual personal refrigerator located in a resident's room?

No. There is no regulatory requirement.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control
DATE: August 1999

What is the correct TB testing regime for residents in nursing homes?

Nursing home residents should be screened for TB prior to admission from settings other than hospitals, nursing facilities or combination facilities and prior to admission from hospitals, nursing facilities or combination facilities. If the resident has not had a documented TB skin test within the preceding 12 months, the two-step skin test should be used. An X-ray alone is not accepted as an appropriate screening tool. If the resident has a documented negative skin test within the preceding 12 months, a single test should be administered and this result recorded as the baseline reading. A resident who has tested positive for TB in the past should not receive further skin testing and should be screened for signs and symptoms of disease. Thereafter, nursing home residents should be screened annually for TB.

If a resident is discharged to a hospital and then readmitted back to the nursing facility, does the resident need a two-step TB test upon readmission?

A hospital admission does not automatically necessitate another round of two-step testing if this has already been documented; in fact, a hospital admission didn't necessitate any further skin testing in the past, if the resident was to be readmitted to the nursing home. The emphasis has always been on new admissions.

What is the TB testing requirement for staff?

All facility staff should be tested for TB using the two-step method within 7 days of hire. If the staff member has not had a documented TB skin test within the preceding 12 months, the two-step skin test should be used. If the staff member has a documented negative skin test within the preceding 12 months, a single test should be administered and this result recorded as the baseline reading. A staff member who has tested positive for TB in the past should not receive further skin testing and should be screened for signs and symptoms of disease. Thereafter, all staff should be screened annually for TB. With the two-step requirement, it is wise to begin the process before there is direct resident contact. It is important for facilities to recognize the signs and symptoms of disease, which is an important part of the screening, instead of relying solely on a skin test.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control
DATE: August 1999

Is it acceptable to use the same lancing device for fingerstick blood sampling on multiple residents?

The best method to use for prevention of bloodborne pathogen transmission is to restrict the use of the lancing device to one resident. Reusing these devices increases the potential for transmission of bloodborne pathogens. This holds true regardless whether this lancing device is spring-loaded or of another type. The CDC cites the fact that HBV circulates in the blood at high titers and can remain viable for at lease one week in blood samples that have dried on surfaces.

Lancets should never be shared. Lancets and disposable platforms (used to stabilize the device on the finger and control the depth of the puncture) on spring-loaded devices should be changed or disposed of after every use of the device. Optimally, fingerstick devices with disposable platforms should be used only on individual residents. If the device is used on multiple residents, after disposal of the lancet and platform, the device should be cleaned and disinfected at the end of the day and more frequently if visibly contaminated with blood.

If the spring-loaded fingerstick device does not employ a disposable platform, the use of these devices optimally should be restricted to one resident. If this device is used on multiple residents, the lancet should be discarded and the device disinfected between residents.

Some fingerstick devices do not have disposable lancets. The use of these devices should be restricted to use in only one resident and should be discarded when no longer needed by that resident, as the device cannot be disinfected.

The FDA recommends disinfecting the devices per the manufacturer's guidelines. When no instructions for disinfection are provided, the device should be discarded.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control
DATE: March 2005

What is the definition of annual TB screening?

A verbal elicitation of symptoms such as can be found in the North Carolina Tuberculosis Manual. This manual can be found online at:

http://www.epi.state.nc.us/epi/gcdc/tb/manual.html

NURSE AIDES

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

Are references required to be checked with previous employer, especially on nurse aides, upon/before employment?

According to the guidelines under 483.130(c), F224, pp51 the facility must "have procedures to screen potential employees for a history of abuse, neglect or mistreating residents. This includes attempting to obtain information from previous employees an/or current employees." This guideline is repeated again under F225, pp52.1.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

Do sitters have to complete the training requirements for nurse aides and be listed with the N.C. Nurse Aide Registry?

No. Federal regulations state that sitters hired by individual residents and their families do not have to meet nurse aide requirements, but emphasize that facilities are responsible for the quality of care provided to their residents.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

Does DFS have the right to verify whether a facility verified the nurse aide's registry number on an application form?

DFS has the right to verify the facility's documentation, but there are no requirements for this verification to be maintained on an application form. Both Licensure and Certification require facility verification that an individual is listed on the Nurse Aide Registry before allowing the individual to work as a nurse aide except under the conditions identified in 42 CFR 483.75 (e) (5) and Licensure rule 3H .2304.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

What is the requirement in OBRA '87 for CPR training for nurse aides and to what level are aides expected to be trained?

First of all, the outcome or performance expectations are that the nurse aide will have an understanding of how to identify cardiopulmonary arrest and be able to react appropriately to an emergency situation when it occurs. An appropriate response would be to immediately notify the charge nurse, assist with gathering equipment and assist with resuscitation if directed by the nurse to do so. It is expected that licensed nursing personnel will actually perform CPR and DFS will not require a nurse aide to be certified in CPR.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

What if the facility does provide at least 12 hours of continuing education each year for nurse aides, but each individual nurse aide does not attend at least 12 hours of continuing education? What recourse does the facility have? Who is ultimately accountable, the nurse aide or the facility?

The facility must provide 12 hours of continuing education to certified nurse aides annually based on areas of weakness as determined in the nurse aide's performance review and special needs of the residents as determined by the facility staff. The facility is ultimately accountable to see that the staff are fully trained and attend continuing education classes. If certified nurse aides do not attend required classes, the facility's recourse is an internal matter and would depend on facility policy. The certified nurse aide must have the required hours to be employed by the facility.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

May long term care staff other than licensed nurses or Nurse Aide Is feed patients?

Yes. Any employee who has been trained in basic feeding techniques and the proper procedures to follow in the event of choking (including the Heimlich maneuver) may feed patients who through a documented assessment have been determined not to have complications with chewing and swallowing. This training should be documented in the employee's personnel file.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

May facilities have contracts with, or otherwise require employees to repay a facility for nurse aide training and competency evaluation programs or competency evaluation programs if the employee does not remain with the facility for a specified period of time? May nursing facilities charge, or otherwise require employees to assume responsibility, for costs associated with nurse aide training and competency evaluation programs or competency evaluation programs?

No. [from the preamble to the final regs]: "The cost of nurse aide training and competency evaluation is borne by the Medicare and Medicaid programs. It is inappropriate for a facility to ask a nurse aide to repay the facility for an expense for which it has already been paid." Further, "No programs that charge fees to any nurse aides who are employed by, or who have an offer of employment from, a facility may be approved by the State."

42 CFR §483.152(c)(1) and 42 CFR §483.154(c)(2) of the final regulations prohibit an aide who is employed by, or who has received an offer of employment from, a facility on the date on which the aide begins a nurse aide training and competency evaluation program or competency evaluation program, being charged for any portion of the program, including any fees for textbooks or other required course materials. Further, if the individual receives an offer of employment from a nursing facility within 12 months of completing an NAT/CEP or CEP, the State will provide for reimbursement on a pro rata basis. 42 CFR §483.158 of the final regulations provides information regarding FFP for nurse aide training and competency evaluation.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

What level of nurse aide can remove a fecal impaction?

Nurse Aide IIs.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

Can nurse aides give enemas? If so, what level of nurse aide and what type of enema?

Nurse Aide Is can give enemas. However, enemas administered by an unlicensed person must be non-medicated and have no systemic effect. Examples of enemas that can be administered by unlicensed staff include soap suds, fleets, and oil retention enemas.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

May a nurse aide who is trained but not certified feed residents?

Yes, provided he/she is an employee of the facility, is enrolled in a DFS approved training program, has completed twenty (20) hours of classroom study, and demonstrates with the skills check-off list that he/she is deemed competent by the instructor.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

Can nurse aides apply products such as Carrington Cleaner and Carrington Skin Barrier to incontinent resident's skin? Can these items be kept at the resident's bedside?

Products such as Carrington Skin Barrier and cleanser may be applied by nurse aides. These products may be kept at the bedside without a physician's order.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides
DATE: November 2007

Can a student who has successfully completed a state approved Nurse Aide Training program be employed by a nursing facility as a Nurse Aide while waiting to take the Nurse Aide Competency evaluation?

According to the Federal Register, the nurse aide training and competency evaluation program (NATCEP) is not complete until the competency evaluation has been completed (Federal Register/ Vol. 58 No. 187 Thursday September 26, 1991, page 48896-48897). If a nurse aide in training is hired after completing the training component and is awaiting to take the competency exam, they can work for a maximum of four months from the date of initial enrollment in the training program (Section 483.75(e)(4)), as long as the facility and the training program have an agreement that the training program has a responsibility to be available to answer questions from its students (Federal Register/ Vol. 58 No. 187 Thursday September 26, 1991, page 48896-48897) during the waiting period. While on duty in the facility, the Nurse Aide in training must be directly supervised by a licensed nurse or registered nurse until such time as the competency evaluation is complete or the end of the four months allowed (483.152(a)(3)).

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides
DATE: October 1996

If a provider employs agency personnel as nurse aides, must the provider contact the registry to obtain confirmation of certification?

The facility is ultimately responsible for making sure all the nurse aides it uses are listed on the Registry. Federal regulation 42 CFR §483.75(e)5 provides as follows:

Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless -- 1) The individual is a full-time employee in a training and competency evaluation program approved by the State; or 2) The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the Registry. Facilities must follow up to ensure that such an individual actually becomes registered.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides
DATE: October 1996

Is a facility required to have a documented check-off list in the personnel file of Nurse Aide Is who are hired with experience if they are listed on the registry?

No. Neither the federal regulations nor licensure rules require a check-off list. However, 42 CFR §483.75(e)(8) requires the facility to complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. Also, see Licensure rule 3H .2211 regarding personnel standards.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

How soon after a Nurse Aide Training Program Coordinator in an approved program resigns, does the Division of Facility Services have to be notified?

Facilities must notify the Nurse Aide Registry at the Division of Facility Services when there are substantive changes to their training program including changes in coordinators, instructors, and curriculum. To ensure the program remains eligible for Medicaid funding of training program costs, facilities are encouraged to notify the State of anticipated changes prior to the actual change. In abrupt or unanticipated changes, facilities are encouraged to notify the Registry as soon as possible.

Reviewed and Revised 1/97

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

Is there a rule or regulation to prohibit an uncertified nursing assistant from establishing an employment pattern of less than 120 days in numerous facilities, thus avoiding the competency requirement?

Unfortunately, no. Although the rule attempts to discourage such a practice, there is nothing to actually prevent this pattern from occurring. Facilities are encouraged to send employees for competency determination as soon as possible after training is completed.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

Page Reserved

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

What are the qualifications for nurse aide training program coordinators and instructors?

Program Coordinator

1. Registered nurse, currently licensed in North Carolina.
2. Minimum of at two years experience as a registered nurse.
3. At lease one year of experience in the provision of long term care facility services, or
   a) experience supervising or teaching of students in a long term care facility, or
   b) work experience in a skilled nursing facility which is a distinct part of a hospital.

Primary Instructor

1. Registered nurse, currently licensed in North Carolina.
2. Minimum of two years experience as a registered nurse.
3. Completed a course in teaching adults, or
   a) experience in teaching adults, or
   b) experience in supervising nurse aides.

Note: The Director of Nursing in a facility may be the program coordinator but is prohibited from performing the actual training. The program coordinator may also be an instructor if he/she is not employed as the Director of Nursing in the facility, and otherwise meets the qualifications for an instructor.

- Other personnel from the health profession may supplement the primary instructor. Supplemental personnel must have at least one year of experience in their field.
- A licensed practical nurse may participate in the nurse aide program but such participation is limited to:
  - demonstrating a specific task or technique according to the program's established procedures;
  - observing an individual's return demonstration of a specific task or technique in comparison to the program's established step by step procedure. Such observation is only for activities that may be delegated by an LPN; and
  - providing evaluative data regarding the individual performance of the task or technique to the registered nurse.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides
DATE: March 1997

When a surveyor conducts a complaint investigation, discovers and substantiates an allegation under Tag F223 when, how, and by whom is the CNA to be reported to the Complaints Branch (NA Registry)?

The administrator shall ensure that the Health Care Personnel Registry Section of the Division of Facility Services is notified within 24 hours or as soon as practicable of all allegations which appear to a reasonable person to be related to patient abuse, neglect, or misappropriation of patient property. The facility shall thoroughly investigate allegations of patient abuse, patient neglect, or misappropriation of patient property and must report the results of the investigation within 5 working days of the incident to the Health Care Personnel Registry Section. Please refer to State Licensure rule 10 NCAC 3H .2210 and federal regulation §483.13(a)(2)(3(4).

Health Care Personnel Registry Section
PO Box 29530
Raleigh, NC 27626-0530
919/715-0159
919/733-3207 (FAX)

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides
DATE: November 1999

Is there a regulatory requirement regarding the age of training materials for the Nurse Aide Registry?

No. However, all facilities/agencies are encouraged to use current, up-to-date materials in training, whether for nurse aide training programs or in-service education. This was recommended by the Nurse Aide Advisory Committee and is covered in the Committee-approved model curriculum introduction which states, "Use of up-to-date textbooks is an important learning resource for students. We suggest that instructors review several textbooks and select one to use in etching the course. Several others may be purchased as reference books depending on budget resources. Each section of the curriculum includes a blank section for listing relevant resources for student reading." Instructors are encouraged to use a variety of materials that they have previewed and feel comfortable with. Some prefer one author/publisher over another. The State doesn't recommend any particular text.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

Page Reserved

NURSING SERVICES

NURSING SERVICES

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

When an antihypertensive medication is being administered and the order contains instructions to withhold the medication if the blood pressure readings are not within the specified parameters, does the nurse have to initial, circle the block and explain why the medication was withheld in the nurses' notes, if the blood pressure readings are documented directly on the MAR?

No. If the documentation indicates that the drug was withheld and the reason for the omission is self-explanatory on the MAR (e.g., blood pressure reading), then it is not necessary that the nurse document any further explanation regarding the omission of the drug.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

When PRNs, especially laxatives, are administered at the end of a shift and insufficient time has elapsed for the medication to be effective, how should the offgoing nurse handle the documentation of the results? Many times the documentation is left for the oncoming nurse and is frequently forgotten.

The nursing report to the incoming shift staff must include instructions for follow-up nursing activity from the past shift. If done properly, responsibility for assessment and charting of the effects of the PRN medication is passed to the staff on the next shift. In other words, the staff on the shift in which results are observed must do the charting.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

On what basis is a facility cited when a small number of the residents are not out of bed during the hours the surveyors are in the building?

Deficiencies are based on individual residents' needs and are not related to the number of residents in bed at a specific time. In assessing an individual resident, the following factors are considered. If a review of medical records, patient care plans, flow sheets, interviews with staff, patients, and families reflect inconsistencies or deviations in following doctors' orders for out of bed activities, level of care plan requirements, a violation/deficiency may result.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Is there a requirement that residents with purulent drainage from a pressure ulcer need to have daily charting?

No. There is no regulation regarding the frequency of documentation for pressure ulcers. Facility policy should address specific charting guidelines. If the purulent drainage constitutes an acute condition (fever or other evidence of an inflammatory/infectious process; sudden onset) or there is a significant change in the drainage (e.g., odor) then daily assessment and documentation are warranted; otherwise, the drainage may be chronic in nature. Only the nurse(s) directly involved in the ongoing care of the resident can make this judgment.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Can "hi-lighters" be used in nurses' notes?

Yes. "Hi-lighters" can be used as long as they do not render notes illegible. Regulations say nurses' notes must be legible and retainable.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

What is the definition of "each employee providing direct patient care?" The statute requires training in the use of suction apparatus, oxygen, etc.. Does this mean nursing assistants? It also requires personnel file documentation of such training. Is licensure as an LPN or RN de facto proof of such training?

Training would be required for staff performing a direct patient care function. Documentation of that training; including skills check list, should be retained by the facility. Registered nurses as well as licensed practical nurses should have skills assessments when hired by a facility. Nurse aides should not administer oxygen nor suction patients; however, familiarity with equipment and/or how to assist with setting it up would be appropriate for nurse aides.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Is it required that intake and output records be maintained on all patients with foley catheters?

No. There is no regulation that requires that intake and output records be maintained on all patients with foley catheters. I&O's should be recorded if the physician orders it or patient's condition warrants it or facility policy requires it.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Measuring contractures - are nurses supposed to be doing this as part of assessment?

No. Measurement of contractures is not a routine part of nursing protocol. A complete nursing assessment and progress notes must include a description of any and all contractures in order to implement necessary interventions. Assessment models (e.g., mild, moderate, severe) should be described in facility policies. Physical therapists and occupational therapists are trained and licensed to measure contractures.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Do injection sites have to be recorded (i.e., Vitamin B_{12})?

Yes. A complete or thorough nursing assessment for patients receiving injections include the documentation of the injection sites. This applies to all types of injections and for ones prescribed as needed, as well as those given on a routine basis (i.e., every day). Documentation of injection sites is beneficial for evaluating if a patient has an adverse reaction and for rotating sites.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Could you clarify the accepted procedure for administration of eye drops?

To properly instill more than one ophthalmic solution, the drops of each SOLUTION should be separated by at least three minutes and preferably five minutes. Procedures for the administration of ophthalmics may be found in numerous nursing manuals.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Is physician's order necessary for bowel and bladder retraining or restorative feeding program?

No. Specific orders may be needed for a laxative or medication if part of the protocol or when speech/occupational therapy are involved (for reimbursement purposes). Facility administration may choose to require orders for these programs, but that is at the facility's discretion.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

If a nurse aide gives a supplemental feeding, can a nurse chart it?

Yes. It is acceptable for a nurse to chart a supplemental feeding.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Please clarify the definition of "days" in the requirements about time frames for completion of resident assessments and care plans - "working" days or "calendar" days.

OBRA '90 amended the original 4-working day requirement for completion of the resident assessment, which was found in OBRA '87. The current requirements are: that the resident assessment be completed within 14 calendar days of admission, that the care plan be completed within 7 calendar days of the completion of the resident assessment, and that the assessment may be amended through day 21 of residency.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

What is an acceptable length of time in which to "answer" a call bell?

Regulations do not specify a length of time, however, staff should acknowledge a call bell as soon as possible to determine the urgency of the resident's needs.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

On the intake and output records of patients requiring tube feedings, are facilities supposed to record both the amount of formula and water given, or can these be combined in the intake records?

The facility has to document compliance with the physician's orders that prescribe the amount of formula, water, and/or other fluids the patient is to receive. The facility also has to document total fluid intake for the patient in each 24 hour period. The record of the tube feeding having been administered by the nurse (which is usually kept on the MAR) should show that the prescribed amounts of each fluid were administered. The intake record records the total amount of fluid consumed overall.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

What constitutes an acceptable rehabilitative feeding program?

The regulations do not prescribe how to structure a restorative feeding program. Licensure and certification require resident assessment to determine feeding, skills, and the implementation of interventions to meet the resident's needs.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Clarification for interpretive guidelines, Tag F328 Injections -

1. Do nursing notes indicate, as appropriate, the resident's response to treatment (e.g., side effects, adverse reactions, problems at the injection site, relief of pain)?

2. Does this mean every patient receiving insulin or other routinely administered injection have responses documented in nursing notes or on the MAR? If so, please give an example of a response.

    1. Yes. Adverse reactions, side effects, problems at injection sites would require documentation and follow up in the medical record. This documentation could be entered in the nurses' notes.

    2. No. If a person receiving routine injections has no problem at any given time relative to the injection, then documentation regarding response to the medication is not needed. However, if a problem does occur, assessment and follow up should be recorded.

REGULATORY FOCUS BULLETIN
FOR YOUR INFORMATION

FILE TOPIC: Nursing Services

NOTE: FYI is an informational and educational service of the Regulatory Focus Committee to assist you in finding the resources for answers to questions regarding issues not regulated by the Division of Facility Services. The source of the information is included for your reference.

May nurses use signature stamps?

"The North Carolina Board of Nursing has taken the position that the only "signature" which qualifies on any official record or document, including a medical record, must be an original signature. Thus, a signature stamp would not be permitted."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

The quarterly summary form for RAI Version 2.0 now has the potential to elicit responses to items that would trigger a RAP if entered as a part of an annual assessment. Computer software and certain forms printed by independent vendors will indicate a RAP has been triggered when entering data during a quarterly assessment. Are RAPs a part of every quarterly assessment?

No. Only if the quarterly assessment indicates a significant change in condition has occurred, are RAPs completed. If a significant change occurred, a complete reassessment including trigger RAPs would be required. However, members of the interdisciplinary team may use the RAP guideline to aid in the review and revision of care plans quarterly if desired.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services
DATE: September 1996

The guidance to surveyors for F314 states "The staging system presented below is one method..." Would it therefore be acceptable to stage wounds according to the new recommendations of wound care experts, i.e., "healing Stage III" for an area that currently "presents" as a Stage I or II, but was a Stage III? Is it agreed that a Stage III despite current appearances, is always a Stage III and may later break back down quickly to a Stage III?

Yes. The guidelines to surveyors for F314 is appropriate for defining maximum depth of tissue involvement when assessing pressure ulcers prior to the beginning of healing. The guidelines do not address the description of an improved ulcer (reverse staging or staging down).

The fourth National Conference of the National Ulcer Advisory Panel published the following position on the practice of reverse staging of pressure ulcers in *Advances in Wound Care Journal*, Volume 8 #4, July/August 1996.

> Reverse staging should never be used to describe the healing of a pressure ulcer.
>
> Healing of pressure ulcers should be documented by objective parameters such as: size, depth, amount of necrotic tissue, amount of exudate, presence of granulation tissue, etc..

The rationale for these statements is that using pressure ulcer staging systems to describe healing must assume that full thickness pressure ulcers heal by replacing the same structured layers as body tissue that was lost. Clinical studies have shown that is not the way the ulcer heals.

Please Note: For the purpose of coding the MDS and Quarterly Review ulcers of all types must be coded by stage. The RAI version 2.0 does not provide for any other type of assessment on this form. HCFA is continuing to study this issue.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Note: This page replaces page 21 in the Nursing Services section due to a corrected answer.

It is written that there be documentation of meal intake and supplemental feedings and snacks. However, it does not specify if this documentation must be in the patient's medical record or if a multi-patient form would suffice. Please clarify. Is daily documentation of food intake required for all patients?

Licensure rule 10 NCAC 3H .2701(d)(5) states: "The dietitian shall spend sufficient time in the facility to assure the following parameters of nutrition have been addressed and that recommended successful interventions have been met:...(5) The amount of meal and supplement consumed to meet nutritional needs."

The facility must have a mechanism for documenting; in the record of each individual resident receiving an in between meal nourishment as a component of a specifically ordered therapeutic diet, whether the resident consumed or refused the nourishment.

The facility must have a mechanism for assessing the resident's food intake in order to record this information in the individual resident's progress notes.

Unless the resident has specially ordered therapeutic supplemental feedings or has nutritional problems or risks addressed in the care plan, there is no requirement for meal by meal documentation of intake.

Please note that the RAI requires intake be assessed for the first 14 days.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Can a treatment ordered daily or BID be initialed by the nurse when completed as a 7-3 or 3-11 treatment on treatment record rather than a specific time like 11:00 am or 5:00 pm?

The treatment must be recorded and initialed upon completion, however, unless the physician orders the treatment to be done at a specific time, it is acceptable, but not prudent, for the treatment record to reflect a daily or BID treatment as 7-3 or 3-11, rather than an actual time. It would be beneficial for the resident to have times indicated on the treatment record to allow sufficient time to elapse between treatments to ensure the effectiveness of the treatment. The nurse for that shift should initial the treatment as being done for that specific shift or the specified time.

REGULATORY FOCUS BULLETIN
FOR YOUR INFORMATION

FILE TOPIC: Nursing Services
DATE: October 1996

Note: FYI is an informational and educational service of the Regulatory Focus Committee to assist you in finding the resources for answers to questions regarding issues not regulated by the Division of Facility Services. The source of the information is included for your reference.

What is the time period that is acceptable/permissible for nurses (or other staff) administering medications and/or treatments to sign off (document) administration when it is not done immediately after the act? In other words, how long before blanks or omissions can be filled by staff? Is circling initials with an explanation on back that entry is late, acceptable?

The North Carolina Board of Nursing has provided the following answer to this question:

"Documentation of medications and treatments should be completed immediately after the procedure is done by the nurse. If the nurse fails to document the procedure, but at a later date, that nurse recalls that it was indeed carried out, he/she can enter the documentation in the medical record consistent with facility policy and procedure for late entry. At a minimum, the late entry needs to include the date the information is entered into the medical record and clearly identify the earlier date when the nursing intervention occurred. The exact procedure to follow, such as circling initials with an explanation elsewhere, should be detailed in the facility policy and procedure for late-entry documentation."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services
DATE: August 1999

Who must supervise a nurse aide who has successfully completed all course requirements including return demonstrations of clinical skills while they are waiting to take the final competency testing within 120 days?

All students in a NATCEP must be under the general supervision of a licensed or registered nurse when they are performing services for residents. Please refer to the attached letter.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

When the M.D. orders continuous oxygen administration must the nurse document this every shift on the treatment MAR or nurses notes?

There are no requirements for a nurse to document the use of continuous oxygen every shift on the treatment MAR or nurse's notes. For Medicare reimbursement purposes' refer to the Medicare Provider reimbursement Manual.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Service
DATE: August 2006

May a Nurse Practitioner serve as Director of Nurses and practice in the facility as well?

No. A nurse practitioner may not serve simultaneously in a dual role as DON and nurse practitioner. The DON is responsible for administering nursing services on a full time basis. The role of the nurse practitioner is as a physician extender in both licensure rule and federal requirement.

Federal regulation 483.30(b)(2) says, "Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. North Carolina does not have a history of receiving requests or granting waivers for the RN requirement and/or the 24-hour licensed nurse requirement.

483.30(b)(3) says, "The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

Full time is defined as 35 hours per week. Registered nurses may share the role of DON. (Licensure does not permit sharing the role of DON. Therefore, this rule takes precedence.)

The licensure rule is more restrictive than the federal regulation.
The licensure rule 10A NCAC 13D .2302 NURSING SERVICES says,
(a) The facility shall designate a registered nurse to serve as the director of nursing on a full-time basis. (35 hours per week)
(b) The director of nursing shall be responsible for the administering of nursing services.
(c) The director of nursing may serve also as nurse-in-charge, only if the average daily occupancy is less than 60.
(d) The director of nursing shall not serve as administrator, assistant administrator or acting administrator during an employment vacancy in the administrator position.

The clinical services of a nurse practitioner are outlined in section .2500 under physician services in the licensure rule and at 483.40(e) Physician Delegation of Tasks in SNFs in the federal regulation.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Service
Date: August 1, 2006

What is the regulatory definition of "elopement" versus "wandering" used to determine compliance?

There are no definitions that "determine" compliance. Administrative law judges have supported citations at 483.25(h)(2) related to failure to provide supervision to residents at a level adequate to prevent accidents, as evidenced by repeated elopements and resident-to-resident altercations, often involving severely cognitively-impaired residents and, in some cases, resulting in serious injury. See http://www.hhs.gov/dab/decisions/dab1726.html . It is the risk and need for supervision rather than the "wandering" versus leaving premises that is the compliance issue. Inadequate supervision can result in a citation whether the resident is wandering on the grounds, in the building or off the premises.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Service

May a Director of Nursing be the instructor for Medication Assistants in a facility?

A Director of Nursing can be faculty for the Medication Assistant course, but may not teach the basic Nurse Aide course, i.e., Nurse Aide Training and Competency (NATCEP).

Revised November 29, 2006

RESIDENT RIGHTS

RESIDENT RIGHTS

RESIDENT RIGHTS

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

If a resident is confused and disoriented to the point of not being able to understand what is being communicated to them and the resident has not been adjudicated incompetent although the physician has deemed the resident incompetent, must the resident sign the admission documents or is it sufficient that the responsible party sign?

Each resident who understands the admission paperwork needs to sign the admission documents. If a resident is clearly unable to understand what is being communicated, even if he/she has not been adjudicated incompetent, the facility needs to document this in the medical record, and the responsible party may sign the documents.

When it is questionable whether a resident is competent or incompetent after an assessment by the facility, it is acceptable for the facility to request signatures from both the resident and the responsible party.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

There is apparent conflict between Resident Rights, 42 CFR §483.10(b)(4), to refuse treatment and frequency of required physician visits, 42 CFR §483.40(c)(1). Since the advent of the Medicare Program in 1966, there has always been the question of requiring physician visits to privately paying residents at fixed intervals. Now, with the aforementioned paradox in mind, the question can be asked if program patients and/or private patients can refuse physician visits at the specified intervals.

Regulation 42 CFR §483.10 (b)(4) provides that the long term care facility resident has the right to refuse physician visits that would otherwise be made in accordance with the prescribed schedule in 42 CFR §483.10 (c)(1). It is expected that a facility should be able to provide evidence of the resident's refusal of such treatment in a manner that would substantiate that the refusal is, in fact, made at the resident's own initiative. Whenever a resident refuses treatment, it is also expected that the facility will assess the reasons for the resident's refusal, clarify and educate the resident as to the consequences of refusal, offer alternative treatments, and continue to provide all other services.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is there a minimum time frame for supervised smoking to assure resident's rights are maintained?

No. Facilities should communicate to residents before admission and through ongoing policies what facility policies are related to smoking. The facility should work with residents who are smokers individually to develop a program that meets the needs of both the resident and the facility.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Can the facility use a "bell" for a patient to ring who cannot push the call bell button due to finger contracture or deformity?

A "bell" can be used in this situation if the patient has the dexterity to use it and it can be heard "on the hall" by the direct care staff.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Does the water pitcher and cup need to be accessible to patients who cannot pour their own water?

No. Water needs to be accessible for staff to provide fluids. This does not necessarily mean immediately beside the patient's bed.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Do cordless telephones meet the requirements of 42 CFR §483.10(k) which states: "The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard?"

The use of cordless telephones is permissible. Privacy should be afforded to all residents when making or receiving calls unless the resident chooses otherwise.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Can a facility be cited for not holding a bed for a Medicaid resident?

A facility is not required to hold a bed for a resident who has been discharged to the hospital unless payment is made by the resident or by someone on his behalf (privately) to retain the bed. However, a resident may have a right to return to the first available bed at the resident's level of care under state or federal law.

Briefly stated, the applicable law and rules are as follows:

(1) Under NC state law, all residents, regardless of payor source or level of care, have the right to the first available bed at their level of care if two things occur within 15 days: (a) the resident is ready to be discharged back to the nursing facility within 15 days from the date the resident was admitted to the hospital; and, (b) the facility receives written notification from the hospital of the specific date of discharge (notice must be within the
15 day period). Under this law, returning residents have priority over new admissions to the facility. This law does not apply if the facility cannot provide the resident with the level of care he or she needs (example: the resident has specialized care needs which exceed the level of care offered by the facility).

(2) Under federal OBRA regulations, all Medicaid-eligible residents are entitled to the first available bed in a semi-private room at their appropriate level of care if the resident still needs care of the type offered by the facility. Under the federal rule for Medicaid-eligible residents, there is no time limit or cut-off point regarding this right as there is under state law.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Will a facility be cited if a resident chooses to be dressed in pajamas rather than street clothes?

No. Residents should be allowed the freedom to dress as they choose.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Please clarify Tag F156 section (iii)

...a posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit.

See approved Regulatory Focus Bulletin listing to be posted in nursing facilities, 42 CFR §483.10(b)(7):

STATE CLIENT ADVOCACY GROUPS

Division of Facility Services - Licensure and Certification Section
2711 Mail Service Center
Raleigh, NC 27699-2711
(919)733-7461

Division of Facility Services - Complaints Branch
2711 Mail Service Center
Raleigh, NC 27699-2711
(919)733-8499 or 1-800-624-3004

Governor's Advocacy Council for Persons with Disabilities
Bryan Building
2113 Cameron Street, Suite 218
Raleigh, NC 27605-1344
1-800-821-6922 / 1-800-638-6810

NC Department of Human Resources Care Line 1-800-662-7030

Local County Department of Social Services

Medicaid Fraud Unit
Division of Medical Assistance
2515 Mail Service Center
Raleigh, NC 27699-2515
(919)733-6681

North Carolina State Ombudsman
Division of Aging
2101 Mail Service Center
Raleigh, NC 27699-2101
(919)733-3983

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Does a resident's right to privacy during medical treatments also extend to glaucometer and blood sugar checks such that performing these procedures at the nurses' station would be inappropriate?

Yes, privacy should be extended during treatments unless the patient chooses otherwise. For example, if the resident comes to the desk asking to have the blood sugar check done, this is permissible as long as other patients who may witness the procedure are not offended.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is it permissible for a nurse (RN or LPN) to put a patient's medication in their food if the patient is combative, confused, and will not take medication orally? If acceptable, is a physician's order needed?

Medications may be mixed with liquids and/or food if the resident refuses to take the medication orally. The nurse needs to be aware of possible food/drug interactions or a listing/resource should be consulted before mixing medications with food. A physician's order to mix with liquid or food is not necessary.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Will a facility be cited for a violation of patient's rights when a resident or several residents are bathed after lunch?

No. This would not be an automatic citation. Patients are allowed to state a preference for bath time, e.g., many patients may prefer an h.s. bath. The patient's right to appropriate care would include face and hands washed before and after meals, incontinent care, mouth care and hair combed. These aspects of personal care should be provided even if the bath is not completed until the afternoon or evening.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Can patient names be used in taped exit conferences?

No. Resident names cannot be used in an exit conference whether it is taped or not.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is it a violation of patient's rights not to receive mail on Saturday?

Logical exceptions apply such as hazardous driving conditions.
See HCFA Transmittal letter 134-94, dated December 1, 1994.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Can surveyors give the names of the patients that were cited as part of a deficiency?

Patient names are to be shared during the survey with the nursing facility staff who have been designated at the entrance conference by the administrator as long as there is not breech of confidence. For example, names of patients who need grooming (nail care, bathing, etc.), patients not turned, repositioned, or released from restraints in a timely manner, acute episodes not followed up, decubiti not assessed or weight loss.

Surveyor interviews of patients are confidential. When a patient requests anonymity, their names are not to be disclosed. A patient's name would not be used, for example, when the patient complained of cold food, staff shortages or call bells not answered.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is it a Resident's Rights violation for "No Code" residents to wear color-coded identification bracelets?

No.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is it a violation of patients' rights for residents to be viewed by nonpatients (visitors, family members of other residents, etc.) during mealtime, especially if they must be fed or assisted? This refers to residents whose eating may be difficult or "messy" or who may drool, cough, have problems chewing or swallowing.

No. Grouping of residents with similar abilities and disabilities may be appropriate during mealtimes. Visitors and family members often visit during this time. It would constitute a violation of residents' rights, however, if the resident preferred privacy during this time. In that case, other provisions should be made to assure residents' privacy.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

If a resident is confused or combative and refuses to take medications, what should the facility do?

The facility is responsible for evaluating the needs of the resident and the resident's concurrent rights to both receive needed treatment and to refuse treatment. A confused or combative patient may have either right violated in the event assessment and evaluation of the individual situation are not carried out. Refusal of treatment by the confused and combative resident must be consistently documented in the medical record. A plan of care must be developed. Involvement of the resident, family, physician, and patient care planning team may assist in the identification of treatment alternatives.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is it permissible to place body diagrams at the head of beds for residents on drainage/secretion precautions and circle or highlight the area of the body that is draining?

No.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is it a violation of resident's rights to administer eye drops or medications in the dining room if the resident does not object?

No, it is not a violation of resident's rights.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is it permissible for facility staff to awaken residents for routine bathing during the night shift? This would not include those residents who themselves have chosen this as their preferred time, nor those residents who are unable to sleep and staff have determined that this might promote sleep.

No.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

The N.C. Patient Bill of Rights, Article 30, Right #3, states: "At the time of admission and during his stay a resident is to receive a written statement of services and related charges. A written receipt must be retained by the facility in a resident's file.

Following admission, where services/charges change, how does the facility comply with the requirement of retaining a written receipt?

A "written receipt" would constitute a statement the resident or responsible party signs that he/she has received the written information. How the facility chooses to do this is at its discretion. It is also appropriate that when a facility's services/charges change, during the course of a resident's stay, this information is also provided to residents and/or legal representatives in a written form. A written receipt of this information would be expected and should be in the resident's file.

Is this written receipt to be signed by resident and/or legal representative?

The "receipt" should be signed by the resident if he or she is competent to sign. In the case of a confused or disoriented resident or incompetent resident the responsible party should sign. If there is any question as to the resident's competency it is recommended that both the resident and responsible party sign the receipt.

If "yes", when representative of disoriented resident is out of town and does not return written receipt, what alternative can the facility use? Is it adequate for the facility to document, in the resident's file, that the facility notified resident and/or legal representative?

If a facility has not received a "receipt" from a "legal representative", it is appropriate to send another copy. Documentation should then be made in the resident's chart as the continuing status of the requests.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Federal regulations at 42 CFR §483.10(b)(1) provide that a "facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility."

Please identify the "rights" of which the resident must be informed.

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights found at 42 CFR §483.10, §483.12, §483.13, and §483.15.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is a resident's memory or recall of having been advised of the rights listed in 42 CFR §483.10(b) the only evidence a surveyor should consider in determining whether the facility advised the resident of these rights?

When conducting resident interviews in which responses show problems (e.g., unsatisfactory responses either with specific resident rights, quality of life requirements, or overall care), surveyors should corroborate the responses by observing staff caring for residents, conducting additional record reviews, conducting additional staff, resident, and family/legal representative or local ombudsman interviews.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Does the phrase "in a language that the resident understands" in 42 CFR §483.10(b) mean that facilities must give the statement of resident rights in language taken directly from the regulations or may the facility paraphrase or restate this language for the resident?

The interpretive guideline for this section states that this phrase means the language regarding rights and responsibilities must be clear and understandable. Some facilities and surveyors have felt in the past that residents must be given a verbatim statement of all resident rights using the regulatory language itself. However, to ensure that residents receive this information in a language they can understand, facilities are free to paraphrase the regulations and restate them in layman's language. There is no requirement that facilities give residents an exact verbatim copy of all resident rights in the same language used in the regulations.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

42 CFR §483.10(b) refers to "all rules and regulations governing resident conduct and responsibilities during the stay in the facility?" Does this refer to a body of law or to internal facility rules and regulations?

According to the interpretive guideline accompanying this regulation, the phrase "all rules and regulations governing resident conduct and responsibilities during the stay in the facility" refers to facility policy or facility rules governing resident conduct while in the facility. This phrase does not refer to any body of laws or regulations. It simply means that residents have the right to be notified of policies or rules which they will be expected to honor while residing in the facility.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

When advising residents of what services are covered under the Medicaid or Medicare program, is it sufficient if the facility clearly tells the resident what is not covered (i.e., what services the resident will be responsible for) and provides the resident with a statement that all other services are covered by the Medicare or Medicaid program?

Yes.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is it a violation of resident rights to post the resident plan of care schedule in the facility newsletter or public places within the facility such as bulletin boards?

Posting the residents' plan of care schedule within the facility does not constitute a violation of resident rights.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Can providers prohibit smoking in nursing facilities?

Yes, under certain conditions. "If a facility changes its policy and prohibits smoking, it must allow current residents who smoke to continue smoking in an area that maintains the quality of life for these residents. Weather permitting, this may be an outside area. Residents admitted after the facility changes its policy must be informed of this policy at admission."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

When surveyors ask for recent transfers, should the list include room changes within the same certified unit?

No.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Does the resident's right to refuse treatment include the refusal of a therapeutic diet? Also, if the resident has cognitive loss, can the responsible party request that a therapeutic diet be changed to a regular diet?

The resident has a right to refuse treatment, to refuse to participate in experimental research and to formulate an advanced directive.

The resident's right to refuse treatment includes the right to refuse a therapeutic diet. When a resident refuses treatment, the facility should clearly document: the refusal to reflect the resident's choice, discussion and education regarding the risks of refusing prescribed treatment, and the exploration of alternative therapies. The implications of the refusal should be evaluated by the facility to determine the need for reassessment and modification to the care plan.

A responsible party may request a change in therapeutic diet to a regular diet. Ultimately, any changes in the diet must be approved by the physician.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident's Rights

Can a facility charge a Medicare, Medicaid, private pay patient for pre-admission bed-hold days, and for bed-hold days if hospitalized? The 3/24/94 HCFA Transmittal Notice says no, but our provider rep says we can.

For pre-admission bed-hold charges - no. According to HCFA Transmittal 112-93 and HCFA Transmittal 51-94, pre-admission bed-hold charges are prohibited. HCFA has no jurisdiction regarding private pay residents.

For bed-hold charges if hospitalized - yes. According to the same transmittals, bed-hold charges for a resident who is in the hospital may be paid by the resident or others on the resident's behalf. However, if a Medicaid recipient or surrogate chooses not to pay for the bed-hold, then the resident still has the right to be readmitted by the facility immediately upon the first availability of a bed [42 CFR §483.12(b)(3)]. Bedhold charges per se do not apply to private paying residents—individual facility policy should address how collection of monies are handled for private paying residents who are hospitalized. Transmittals are included.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident's Rights

Situation: A resident who has not been declared incompetent and has a long standing diagnosis of Schizophrenia is increasingly noncompliant with physicians' orders to the degree that other residents are complaining that their rights are being violated. The resident refuses any form of hygienic care.

1. Are there any special guidelines or procedures to follow when this resident would be homeless if discharged?

The facility should involve the patient representative regarding discharge planning as appropriate. When a discharge destination is not identified, the facility should involve all available resources including:

Local Mental Health Authority
DSS
LTC Ombudsman and/or Community Advisory Board
DFS for technical advice when applicable.

(Note: F152 addresses the resident who has not been adjudged incompetent.)

2. Should a PASARR for change in condition be completed?

A PASARR should be completed to reflect a significant change in the patient's behavior and request a Level II screening be completed by mental health. The facility can also petition to the court to have the patient evaluated for commitment procedures.

3. How can a behavior modification program be implemented when the resident will not comply? To what extent can privileges be withheld or rewards utilized in the long term setting?

Behavior modification programs which include withholding of privileges and offering rewards are appropriate in a long term care setting when thorough assessment has been accomplished and a care plan devised for that behavior modification by an appropriate interdisciplinary team. This interdisciplinary team should include a mental health professional when at all possible.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident's Rights
DATE: September 1996

How should facility staff handle surveyor requests to enter patient care areas while care is being provided? What should facility staff do if the surveyor wants to examine a particular part of the resident's anatomy?

Residents have the right to be treated in a manner that protects the privacy and dignity of their bodies. Facility staff should protect a resident's privacy and dignity at all times, including those times when a survey team is in the facility.

- Interviews by surveyors. If a surveyor asks to interview a resident or staff member at a time when the resident is undressed, the staff member should request that the surveyor return later when the resident is clothed.

- Surveyor asks to observe possible quality of care problem not readily observable. When indicators exist suggesting a quality of care problem that is not readily observable (e.g., leg ulcer covered with a dressing, or a sacral pressure sore), the surveyor should ask for facility staff to assist in making an observation by removing, for example, a dressing or bedclothes. However, if the procedure has the potential to cause pain or discomfort, the surveyor should wait until the next scheduled time of treatment. Such resident care observations should be made by surveyors who have the clinical knowledge and skills to evaluate compliance.

- Surveyor observations of resident's genital or rectal area or female breast area. If a surveyor asks to observe a resident's genital or rectal area or a female breast area to confirm and document suspicions of a care problem, a member of the facility's nursing staff must be present and the resident must give clear consent (see below). Also, only
  a surveyor who is a licensed nurse, a physician's assistant or a physician can make observations of this type.

- Consent for observations of genital, rectal or female breast area. For a surveyor to observe any of these areas, the resident must give clear consent. If the resident is unable to give consent (e.g., is unresponsive or incompetent) and has a legal surrogate
  (family member who can act on resident's behalf or other legal surrogate), the surveyor should ask this person to give consent. If there is no consent given by the resident or legal surrogate, a surveyor may only observe a resident's genital, rectal or female breast area if the surveyor has determined there is a strong possibility that the resident is receiving less than adequate care which can only be confirmed by direct observation.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights
DATE: October 1996

Does the resident have the right to choose his/her own pharmacy and how often can he/she change that request?

The facility is to develop and implement policies and procedures regarding the drug distribution system. The patient should have the right to choose his/her own pharmacy if the dispensed product is compatible with the system employed in the facility and properly labeled. The facility is ultimately responsible for ensuring that medications are available. Frequency of change is not regulated, but is determined by facility policy to assure ongoing availability of drugs.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights
DATE: October 1996

Can a family council deny membership to their council because a resident's family member is also an employee of the facility?

The resident is a beneficiary and is entitled to all rights afforded other residents. An employee related to a resident must participate as a family representative, not as a staff member.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights
DATE: November 1996

42 CFR §483.10(n) states that a resident has the right to share a room with his or her spouse when married residents live in the facility and both consent to the arrangement. However, if only one spouse is physically and/or mentally able to consent to rooming together, do the spouses have the right to room together?

Yes. Married couples have the right to room together, even if only one spouse is physically/mentally able to consent.

Would it matter if the family members for either spouse did not want the spouses to room together? Assume for the purposes of the question that the incompetent resident does not have a guardian.

No. The opinions of family members are of no legal consequence unless there is good reason to believe that the health or safety of the incompetent spouse would be jeopardized. The facility should pursue this type of problem utilizing the care planning process.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident's Rights
DATE: January 1997

Does the licensure rule regarding the reporting and investigation of abuse, neglect, and misappropriation apply only to suspected staff abuse, or does it also apply to resident-to-resident abuse?

The licensure rule requiring reporting of suspected abuse to DFS is limited to suspected staff abuse, neglect or misappropriation. There is no requirement to report resident-to-resident abuse, neglect or misappropriation to DFS. However, the facility is responsible for identifying and investigating all incidents of suspected resident abuse, neglect or misappropriation whether by staff or others (including resident-to-resident abuse).

The new Health Care Registry law enacted in 1996 requires nursing facilities to notify DFS of all allegations against all unlicensed employees which appear to a reasonable person to be related to abuse, neglect, misappropriation of resident property, misappropriation of property belonging to a nursing facility, diversion of drugs, and fraud against a nursing facility or resident by an unlicensed employee. DFS has developed a reporting form for facilities to use. The facility must make its report to DFS within five working days of the date the facility becomes aware of the alleged incident.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident's Rights
DATE: January 1997

When a DFS team is conducting a survey, can patients in Medicare and/or Medicaid beds deny access of their records to surveyors?

No. According to federal regulations, a nursing facility can be terminated from the Medicare/Medicaid program if it refuses examination of records necessary for verification of information it furnished as a basis for payment under Medicare 42 CFR §489.53(5) and under Medicaid as a part of the Medicaid agreement with the facility. Since a fundamental prerequisite for payment to a nursing home under Medicare/Medicaid is compliance with requirements for participation, HCFA's authority and/or the Medicaid agency's authority
to terminate under these regulations extends to the facility's cooperation with the survey agency's certification activities.

State law allows a resident to object in writing to inspection of his/her record by DFS. However, federal law supersedes state law when a resident is in a Medicare and/or Medicaid certified bed.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

What is the nursing home's responsibility in providing information to residents about Medicaid's spousal impoverishment rules?

The facility should advise the resident to contact the local department of social services for information about spousal impoverishment. The facility should provide the resident with that agency's telephone number and, if needed, assist the resident in contacting the agency.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Under federal law, movement of a resident from one room to another within the same certified facility is not considered a "transfer or discharge" but is considered a roommate change. Under federal law, roommate changes are not subject to the 30-day notice requirement applicable to transfers or discharges. Instead, residents must only be given "prompt" notice. However, the North Carolina Patient Bill of Rights at N.C. G.S. 131E-117(15) requires at least a 5-day advance notice to the resident before a transfer or discharge and the interpretive guideline states that this includes movement of a resident from one location to another within the facility. Does this mean the facility must give residents a five-day notice even where the relocation is only a roommate change under federal law and is not a transfer or discharge?

No. G.S. 131E-117(15) requires at least five days' notice before a transfer or discharge (unless an earlier transfer or discharge is ordered by the attending physician). However, the North Carolina statute does not define a "transfer or discharge" to include movement of residents from one room to another within the same facility (i.e., roommate changes). Nor do any applicable state regulations define transfer or discharge to include movement of residents within the same facility. Therefore, there is no statutory or regulatory basis in state law for equating a roommate change with a transfer or discharge or for requiring a 5-day notice for roommate changes. Therefore, if a facility determines that a planned move of a resident is a roommate change and not a transfer or discharge under federal law, the facility must only give "prompt" notice (which is not defined as a prescribed number of days) and the North Carolina statute does not require a minimum five days' notice. If the facility determines that the move is a transfer or discharge, it must honor the federal 30-day notice requirement (unless an exception applies under federal law). In so doing, the facility will automatically meet the state's less stringent 5-day notice requirement for transfers and discharges. A non-certified facility or unit (not required to follow the federal requirements) must give the resident a 5-day notice prior to a transfer or discharge, but is not required to give such notice prior to a roommate change.

It should be noted, however, that federal law does define transfer or discharge to include some roommate changes if the relocation of the resident is across distinct part lines (with some exceptions). All North Carolina facilities which are certified for participation in either the Medicaid or Medicare programs are subject to the federal rules on transfer and discharge, and must comply with federal limits on transfers and discharges in certified beds. The only facilities which are exempt from the federal requirements are those which are not certified for participation in the Medicaid or Medicare programs (this may include the noncertified portion of a facility with certified beds).

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident's Rights

We understand that a patient rights issue exists when a patient is constantly yelling and this behavior is disruptive to the normal daily routine of other residents on her unit and in the facility. What are the guidelines that a facility needs to follow to protect the rights of the other residents?

The rights of other residents include the rights to be treated with consideration, respect, and full recognition of personal dignity; to receive care, treatment and services which are adequate and appropriate; to be free from mental and physical abuse; and to associate and communicate privately and without restriction. The facility must attempt to assess the reason for the behavior, including a complete resident assessment utilizing the appropriate resident assessment protocols (RAPs) to determine the underlying problems (e.g., potential pain the resident is unable to communicate). Causal factors should be relieved whenever possible.

The yelling resident's rights should be balanced against the rights of other residents to peaceful living conditions. If an assessment has been completed, and all possible ways of dealing with the disruptive resident have been exhausted, it may be necessary to transfer or discharge the patient under the regulations found at 42 CFR §483.12 Admission, Discharge and Transfer Rights. Thorough documentation in the medical record of the results of assessment, interventions, etc. is essential.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident's Rights

When a resident requests or volunteers a discharge to another facility or movement outside of a distinct part to another location in the facility (e.g., from a Medicare/Medicaid bed to a Medicaid bed) are notice of discharge and appeal rights forms required?

No. According to DMA's Chief Hearing Officer (Joseph Whiteley):

> "Transfer and discharge requirements at section 42 CFR §483.12(a) apply when the facility initiates the transfer or discharge. The purposes of the requirements are to insure that residents remain in the facility in the absence of any of the six criteria at section 42 CFR §483.12(a)(2), and to inform residents of their rights to question the decision of the facility relating to their transfer/discharge. If a resident or resident's legal representative initiates a transfer or discharge voluntarily, then these requirements do not apply (see attached HCFA Program Issuance Notice, Region IV, Number 147-93 dated August 20, 1993)."

When there are questions regarding specific cases, providers should contact their own attorneys or the attorney for the North Carolina Health Care Facility Association as the DMA Hearing Unit cannot engage in ex parte conversations about how to give notice of transfer/discharge to a specific resident, nor can they give legal advice. Transfer/Discharge hearings are evidentiary hearings in the sense that witnesses are sworn and the hearing is recorded.

In some cases, providers have lost hearings because of technicalities. In order to make sure cases are not lost due to technicalities, providers should be very familiar with transfer/discharge regulations and any other regulations pertaining to discharge planning. Following are regulations that speak to transfer/discharge and planning.

483.10(0) Tag 177 483.12(a-b) Tag F200A- F208 483.15 (g)(1) Tag F250 483.20(e) Tag F283, F284

In addition, providers should make sure that assessments, care plans and other documents that may be relative to the transfer/discharge issues accurately reflect the resident's condition. For example, if a resident is jeopardizing the health and welfare of other residents, this should be reflected in appropriate assessment data and goal planning. There should be clear documented evidence that the resident is endangering others.

In an emergency situation, like transfer to a hospital, if appeal rights and forms cannot be transported with the resident or the resident has a legal guardian, then the appropriate information should be provided as soon as possible. For example, if the resident leaves the facility late at night, then the information can be sent the next day.
When a facility asks the resident to move to another room across distinct lines, the facility is required to tell him that he does not have to move and to inform him of all his rights regarding transfer/discharge. In addition, this information should be documented in the resident's record.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights
DATE: February 1997

On rare occasions it is not safe or practical for a resident to have a call bell within complete access. Examples: a resident who wraps the cord around their neck, a resident who wraps it around their arm causing skin tears, or a resident who is completely incapable of using the system as testified to by the physician, family, and caregivers. Can a facility restrict complete access to a call bell under certain circumstances if they develop a policy addressing this issue?

Each resident's ability to have access to the call bell should be reviewed by the patient's care planning committee. When the call bell becomes a safety issue for the resident, or the resident's level of orientation renders him/her unable to understand its use, access should be limited and other methods of assuring communication and safety should be identified.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is it a violation of resident's rights for a complaint nurse/investigator or surveyor to mark the diaper (waistband closure) or underpad in order to monitor the care of the incontinent resident?

Diapers can be marked if the investigator has permission from the resident (must be cognitively aware). If the resident is not cognitively aware, the investigator must have permission from a family member.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights
DATE: July 1997

Does failure to complete any of lines one through eight on the Notice of Transfer or Discharge form automatically invalidate the planned transfer or discharge?

Yes. The resident has the right not to be transferred or discharged unless the proper notice is given. 10 NCAC 26I .0302(b), regarding Transfer and Discharge Requirements states that, "Failure to complete the Notice of Transfer or Discharge form shall result in the notice of transfer or discharge being ineffective."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights
DATE: August 1998

We are concerned about our patients that are transferred by EMS and other patient transport services, and are out of the building for an extended length of time. Can we be cited for issues involving personal care while they are with the transport service?

The Division of Facility Services Long Term Care Licensure and Certification Section does not regulate EMS. However, when arrangements are provided under private service agreements, the facility assumes responsibility for meeting the needs of the resident and should include their expectation for the provision of care in the agreement made with the transport service.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights
DATE: August 1999

Does tag # 174 require the facility to install a cordless telephone?

No.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights
DATE: March 2000

Is it necessary to always revisit the resident/family information about Advance Directives and the Do Not Resuscitate order when patients are re-admitted to the facility? Would this be determined by how long they are away from the facility before return, or would this be determined by a change in status? How would you define a "change in status?" Is there is a federal requirement that readmissions be "re-given" the admission packet, inclusive of the Do Not Resuscitate order?

Facility policy should address how the facility will treat re-admissions to their facility in regard to Advance Directives. Refer to F156 Guidance to Surveyors. DNR orders are not expressly regulated by the federal regulations under 483. The physician writes DNR orders. The facility should have policies regarding the establishment of such orders and when those orders need to be revised based on State law.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights
DATE: March 2000

Who is the legal surrogate decision-maker for medical treatment choices when a resident is cognitively impaired and has not named a formal health care power of attorney or written a living will?

Ethical guidelines consistently endorse the use of family surrogates to make health care decisions when a patient is cognitively impaired. The North Carolina Natural Death Act indicates a sequence of family surrogate authority -- a legal guardian, or a spouse, or a majority of relatives of the first degree. This sequence is natural for many families, and should be used in cases of terminal and incurable illness or persistent vegetative state. In other health conditions, the law is not specific, but ethical guidelines and clinical best practices endorse the use of family surrogates who have the best knowledge of the resident's own values and preferences.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights
DATE: August 2000

Is a facility required to accommodate patient food requests outside the routine items ordered for menus? For example: If a patient requests raw broccoli and cauliflower, but the facility does not usually carry the item in stock, are we required to make an individual purchase for that patient or can we ask the family to provide special requests such as this? If 100 residents all had individual requests, where is the cut-off for accommodating preferences?

If the facility can easily accommodate the food request, then it should be honored. It is not expected that the facility has to order a case of raw broccoli to accommodate the resident or make a special trip to the grocery store to purchase the broccoli. Families can be asked to bring in food items that are not a part of the routine items ordered for menus. If many residents are making individual requests, then the facility should establish a resident committee, or use the resident's counsel to review menu items and make recommendations to establish new menus.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights
DATE: August 2000

Is it a breach of confidentiality to post a patient's name outside the room next to the entry to the room?

No. However, if the resident or the resident's legal representative/responsible party does not want his/her name posted, then the facility should accommodate the request.

REGULATORY FOCUS BULLETIN
FOR YOUR INFORMATION

FILE TOPIC: Resident Rights
DATE: November 2000

Due to recent instructions from HCFA, surveyors will cite resident-to-resident abuse under F Tag 324 when the abuse is not willful. In addition, resident-to-resident abuse may be cited at F224. This decision is based on a recent ruling by the Departmental Appeals Board. There will be some future discussions by HCFA in this area.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights
DATE: November 2000

A resident is ready for discharge from the hospital back to the nursing home, but there are no beds available for the resident and he/she has to be transferred to another nursing home. Does this resident have the right to the first bed opening in the original nursing home?

No. According to Fred Gladden in HCFA Central Office, the first facility is under no obligation to provide the resident with a first bed opening in the original nursing home.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights
DATE: April 2001

If survey results are available in public areas without any restriction to access, must the facility also post a notice of the location of these documents?

Yes. Regulation 483.10(g)(11) requires the facility to "make the results available for examination in a place readily accessible to residents and must post a notice of their availability (F167)."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights
DATE: November 2004

<u>If a resident is discharged/transferred to the emergency room or hospital must a notice of discharge be issued?</u>

Yes Although it is not possible to give the 3O~day notice, the federal regulations found at F203 require that a notice with specified content "*be made as soon as practicable*" for an "*immediate transfer*" due to an "*urgent medical need*".

PHARMACY

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

What is acceptable practice for dating and using multidose vials?

An open multidose vial may be used up to the expiration date on the label as long as the product does not show any evidence of contamination such as particulate matter or discoloration, unless contraindicated or suggested otherwise by the manufacturer. With the advice of the Quality Assurance Committee and medical director, the facility should establish a policy that will ensure a stable and non-infectious product such as dating the vial when initially opened.

REGULATORY FOCUS BULLETIN
FOR YOUR INFORMATION

FILE TOPIC: Pharmacy

NOTE: "FYI is an informational and educational service of the Regulatory Focus Committee to assist you in finding the resources for answers to questions regarding issues not regulated by the Division of Facility Services.

Must insulin be refrigerated?

The temperature for storing insulin should not exceed 75 degrees Fahrenheit. Studies regarding the stability of insulin stored at room temperature provide various time frames, 30 days to 18 months, but none of the studies have been performed for temperatures greater than 75 degrees Fahrenheit. It is the facility's responsibility to develop a policy regarding the storage of insulin.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

How quickly should a consultant pharmacist submit his/her written report to the facility after monthly reviews?

Federal regulations require documentation of services and for written reports to be submitted to the physician and director of nursing.

Prompt action is necessary if the pharmacist observes a situation which may cause harm to a patient, e.g. adverse reaction to a drug or medication error. The facility and pharmacist do open up liability issues when findings relative to drug regimen reviews are not submitted and/or documented, as well as followed up, in a timely manner.

Licensure rule .2603(a) states that potential drug therapy irregularities or discrepancies must be reported monthly following the pharmacist's assessments.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

What are the limitations for borrowing drugs?

Licensure rule .2306(d)(3) prohibits the borrowing of drugs except in an emergency. An emergency in this instance is a matter of professional judgment. When medications are borrowed, there is to be proper documentation and prompt replacement in accordance with the facility's policies. The administrator, director of nursing, and pharmacist should be made aware of problems with medications not being available. The facility should assure policies and procedures regarding the ordering, delivery and the establishment of a reliable drug procurement system and that utilization of emergency drug kits are followed in order to prevent the need to borrow drugs.

*This is only the viewpoint of the Division of Facility Services and does not represent the viewpoints of other regulatory agencies, such as the N.C. Drug Commission, involved in nursing homes.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

What is an acceptable "drug not available" policy?

Licensure rule .2601(b) states: "The facility shall be responsible for obtaining drugs, therapeutic nutrients and related products prescribed or ordered by a physician for patients in the facility. Resources such as hospitals, wholesalers, and other pharmacies in the community should be contacted to obtain drugs that are not available at the provider pharmacy. If the drug cannot be obtained within a reasonable time period, the physician should be notified."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

May drugs be stored at bedside with a physician's order even if a patient is not capable of self administering a medication?

Yes, for staff convenience if the facility has policies for proper secure storage of drugs at the patient's bedside. These policies are to be implemented for the safety and welfare of all patients in the facility.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

What is an acceptable time frame for drugs being available after ordering?

The interpretive guidelines for Tag F425, 42 CFR §483.60 state: "The facility is responsible under 42 CFR §483.75(h) for the "timeliness of the services." A drug, whether prescribed on a routine, emergency, or as-needed basis, must be provided in a timely manner. If failure to provide a prescribed drug in a timely manner causes the resident discomfort or endangers his or her health and safety, then this requirement is not met."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

What is an acceptable margin of error in pouring a dose of liquid medication?

Although there are drugs that would not be harmful if the exact dose was not administered, there are too many potent drugs that require precise dosage evaluation. Therefore, there is no certain percentage of margin of error that can be accepted for all liquid medications due to the significance of error being based on the medication being poured.

Staff should utilize measuring devices that have increments for the amount to be poured. Depending on the medication, nursing or pharmacy personnel may contact physicians and request a change in the order to a dosage that is more practical to measure accurately.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

Note: Replaces page 9 in Pharmacy section due to corrected answer.

What constitutes a medication error? At what point should a medication error be written up as an incident?

Licensure rule .2306(d)(1) states: "All medications or drugs and treatments shall be administered and discontinued in accordance with signed medical orders which are recorded in the patient's medical record." Anytime a dose of medicine is given in a manner that deviates from the way the physician ordered it or from facility policy there is a medication error. A medication error has occurred if one or more of the following is not correct as specified in the order: the patient, the dose, the drug, the route, or the time of administration. Some documentation of a medication error should exist, and in certain situations an adverse incident report should be filed. Every facility should establish a policy regarding medication errors, including what steps are to be taken to rectify the problem, if possible, and what sort of documentation is warranted.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

Should PRN medications be charted on both sides of the MAR?

Nurses are responsible for charting the medication and amount given, the reason and the effectiveness of a PRN medication. This information is to be documented in the medical record, such as on the back of the MAR or in the nurses' notes. Documentation should be consistent, and any medication administered is to be properly documented on the front of the MAR.

REGULATORY FOCUS BULLETIN
FOR YOUR INFORMATION

FILE TOPIC: Pharmacy

NOTE: "FYI is an informational and educational service of the Regulatory Focus Committee to assist you in finding the resources for answers to questions regarding issues not regulated by the Division of Facility Services.

How long are stock drugs good after they are opened?

Expiration dates on labels are based on stability studies of the drug product in the original unopened container. Even so, drugs are considered to be in date until the manufacturer's expiration date has lapsed, assuming proper storage and packaging as recommended by the manufacturer. Exceptions apply to any drug that a manufacturer has identified as having a shortened expiration date once opened, e.g. Lasix Solution and sterile irrigation solutions.

To ensure that a drug product meets standards of identity, quality and purity at the time of use, consultant pharmacists should develop, coordinate and supervise proper policies and procedures of individual facilities, including storage and labeling.

Routine medication not dispensed in their original containers should carry an appropriate expiration date as determined by the dispensing pharmacist.

REGULATORY FOCUS BULLETIN
FOR YOUR INFORMATION

FILE TOPIC: Pharmacy

NOTE: "FYI is an informational and educational service of the Regulatory Focus Committee to assist you in finding the resources for answers to questions regarding issues not regulated by the Division of Facility Services.

What is the acceptable time period for expiration dates on medication labels that are not in the original manufacturer's packaging, but prepackaged by individual pharmacies in unit dose?

It should be emphasized that pharmacists have a professional responsibility to ensure the integrity of all drug products under their supervision.

The current edition of the US Pharmacopoeia (XII) states that a dispenser must take into account a number of factors in determining reduced expiration dating. Relevant factors include the nature of the drug, the container, and the storage conditions. Current USP policy states "Unless otherwise required, the dispenser may, on taking into account the foregoing, place on the label of a multiple-unit container a suitable beyond-use date to limit the patient's use of the drug. Unless otherwise specified in the individual monograph, such beyond use date shall be not later than (a) the expiration date on the manufacturer's container, or (b) one year from the date the drug is dispensed, whichever is earlier.

The USP also provides that for Single Unit Containers and Unit-Dose Containers for Non-sterile Solid and Liquid Dosage Forms, "In the absence of stability date to the contrary, such date should not exceed 1) 25% of the time remaining between the date of repackaging and the expiration date on the original manufacturer's bulk container, or 2) six months from the date the drug is repackaged, whichever is earlier.

According to available HCFA interpretations, the information above is only a guideline for reduced expiration dating for drugs dispensable in multiple-dose containers. Since the language is permissive, the pharmacist is free to estimate a reduced expiration date based on the relevant factors listed above. HCFA has also stated through a HCFA 1988 memorandum that "bingo" cards (punch cards or "bubble packs") are considered to be unit dose packages. USP standards also consider this type of package to be "unit-dose."

References

1. US Pharmacopoeia, XXII, Rockville, MD, US Pharmacopeial Convention, 1990.
2. Feinberg, J.L. "Expiration date labeling...", Consult Pharm 1989, 438, 440.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

If a resident wishes to keep an over-the-counter medication at his/her bedside, does the interdisciplinary care planning team need to be aware of such a practice and does a notation need to be placed in the resident's care plan?

Yes. Over-the-counter medication may be kept at the bedside for self administration. Regulation 42 CFR §483.10(n) states that "an individual resident may self administer drugs if the interdisciplinary team, as defined by 42 CFR §483.20(d)(2)(ii) has determined that this practice is safe." The interpretive guidelines also address documentation in the care plan and the storage of these drugs for self administration.

State licensure regulations require drugs that residents wish to keep at the bedside be stored in a manner to prevent easy access by wandering, confused residents. This storage may include a closed cabinet, private bathroom, or closed drawer. A physician's order is required for residents to self-administer medications and the order should indicate that medications may be stored at the bedside. Facility policy dictates issues such as labeling.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

Note: Replaces page 14 in Pharmacy section due to corrected answer.

Is it a deficiency to leave expired drugs on the medication cart since the facility has thirty days to return expired drugs?

Expired medications are to be removed from areas storing in-date medications, prior to or at the time of expiration. The facility is to have a designated area for the storage of expired products until the products are disposed of in accordance with the facility's policy. Nurses should check the expiration dates of medications, especially ones not used routinely, prior to the administration or use. Inappropriate storage of expired drugs is regarded as a safety and environmental issue.

Regulation 10 NCAC 3H .2605(a)(4) regarding the removal of expired drugs by the pharmacist within 5 days after the expiration date to the removal of drugs from the facility, not the removal of expired medications from storage areas such as medicine carts or cabinets in medication rooms.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

How are Pharmacy Key Indicators found in Appendix N applied in the survey process?

This list of drug irregularities or indicators developed by the federal government should be used as GUIDELINES by the pharmacist performing drug regimen reviews and by non-pharmacist surveyors in the assessment of the performance of drug regimen reviews. The indicators are meant to be minimum standards for the pharmacist.

The pharmacist conducting reviews is responsible for identifying any irregularity and notifying someone with the authority to correct the potential problem. The facility's responsibility is to ensure that recommendations by the pharmacist are reviewed and any action to be taken is documented and followed up. The surveyor is responsible for determining whether identification and notification has taken place.

Note: Appendix N is attached.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

If a resident is sent to the hospital and admitted but the family holds the room -- are the drugs returned to the pharmacy or do they remain in the patient's medicine drawer on the medication cart? If medications are returned to the pharmacy, can the pharmacist send the same drugs back if the resident returns to the facility with the same medication orders?

Refer to Licensure regulation 10 NCAC 3H .2605(b). Drugs may be held for not more than 30 days after the date of discharge. The storage and disposition of residents' medications is to be in accordance with the facility's policy and procedures. Once the drugs are returned to the pharmacy, the pharmacist needs to use his/her professional and legal judgment regarding the disposition of the medications.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

Due to the conversion of dosage from grains to milligrams, could a facility be cited for giving 300 mg of ferrous sulfate rather than 325 mg although both are 5 grains?

No. Differences among companies exist for ferrous sulfate, ASA, ferrous glucomate and Tylenol. This can lead to confusion in dosage conversions. The facility should be aware of the strength that its pharmacy dispenses, and physician orders should be the same as what is dispensed.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

May drugs have automatic stop orders?

Automatic stop orders should be established for all drugs. The majority of drugs such as antihypertensives will have a stop order that coincides with the renewal of orders (e.g., 30 or 90 days). Other drugs such as antibiotics for acute episodes will have a shorter stop order (e.g., 10 days).

Automatic stop orders should specify the type of product. For example, if the facility's stop order for corticosteroids is 14 days, then all corticosteroid products should be included, unless otherwise stated in the facility's policy.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

What is the acceptable length of time that medications can remain in the facility after a resident is discharged from the facility? (The resident has the intent to return back to the facility from the hospital.)

Thirty (30) days. Licensure rule 10 NCAC 3H .2605(b) states: "Upon discontinuation of a drug or upon discharge of a patient, the remainder of the drug supply shall be disposed of promptly. If it is reasonably expected that the patient shall return to the facility and the drug therapy will be resumed, the remaining drug supply may be held for not more than 30 calendar days after the date of discharge or discontinuation."

Note: Medicaid residents are allowed one dispensary fee per month.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy
DATE: March 1997

Many medications have recommendations to be administered with food to prevent GI related adverse effects (e.g., NSAIDs, Ticlid, Cytotec, Trental, designated antibiotics, ...), and physician orders for these medications read "...with food." Would a package of graham crackers or a package of saltines meet the intent of the order and satisfy regulations for those drugs which require administration with food? (The physician is satisfied with graham crackers or saltines.)

A package of graham crackers contains three 2 1/2" x 2 1/2" crackers and a package of saltines contains two 2" x 2" crackers, and are acceptable amounts of food to be used when administering medications. Although there are no specific parameters given for the amounts of food to be taken with medications, a teaspoon of applesauce would not meet the intent "with food." Three to four ounces of semi-solid food is recommended. The "with food" is intended to prevent possible GI distress and/or aid in drug absorption. Therefore, mealtime would be an appropriate schedule unless otherwise ordered or contraindicated.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy
DATE: September 2004

What are facility responsibilities in regard to residents receiving medications via the Internet, catalogs, or other mail-order vehicles?

The Social Security Act, sections 1819(b)(4)(iii) and 1919 (b)(4)(A)(iii), places the responsibility for accurately administering drugs on the facility. This gives the facility the right to define specific standards for labeling, packaging, storing, processing, and administering of drugs. These provisions of the act allow the facility to develop policies to ensure the standards are upheld. Therefore facility policies would determine permissible methods of obtaining medications and biologicals.

1919(b)

(4) PROVISION OF SERVICES AND ACTIVITIES.—
(A) IN GENERAL.—To the extent needed to fulfill all plans of care described in paragraph (2), a nursing facility must provide (or arrange for the provision of)…
(iii) pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident; …

1819(b)

(4)PROVISION OF SERVICES AND ACTIVITIES.—
(A) IN GENERAL.—To the extent needed to fulfill all plans of care described in paragraph (2), a skilled nursing facility must provide, directly or under arrangements (or, with respect to dental services, under agreements) with others for the provision of— …;
(iii) pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident; …

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy
Date: August 2006

Must a facility allow a resident to use a pharmacy of choice (proprietary or Veteran's Administration etc.) to dispense prescribed drugs when the pharmacy procedures and practice routinely prevent timely or accurate procurement of the drugs thereby creating a failure to comply with the resident's medical plan of care?

No. The facility must explain the reasons the resident's choice of pharmacy cannot be utilized to the resident so not to be interpreted as a violation of the right to choose.

PHYSICIAN SERVICES

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

Is it required that physicians sign anything other than orders and progress notes when they visit the facility (e.g., care plans)? If so, please provide the regulation, interpretive guidelines, and/or surveyor probe/procedure.

No. Tag F386 states, "The physician must write, sign, and date progress notes at each visit, and sign and date all orders." The interpretive guidelines for this tag state that the physician may transmit orders by facsimile machine if certain conditions are met. One condition is that the physician should have signed the original copy. It is not necessary for a physician to re-sign the facsimile order when he/she visits the facility. The interpretive guidelines for tag F385 state that a physician must participate in care planning, but do not require that the care plan be signed by a physician.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

When standing orders are initiated per facility policy that have been previously approved by medical staff in an individualized manner on the resident's medical record, is it necessary to fill out and have a physician sign a telephone order slip?

No.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

Is it necessary to have a specific order for giving a medication with juice?

No, if this does not conflict with the facility's policies, dietary restrictions or physician's orders. There are certain medications that should not be given with juices or other liquids and these should be addressed by the pharmacy consultant, i.e. by auxiliary labeling.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

What are acceptable procedures for obtaining admissions orders?

Medications and other orders should be verified with the attending physician upon admission.

Under what circumstances can orders in a hospital discharge summary or transfer form be acceptable?

Discharge medications on the summary or transfer form are acceptable after verification by the attending physician and transferred to the record containing current orders.

Do admission orders have to be signed by the physician on the day of admission?

Admission orders do not have to be signed by the physician on the day of admission. They can be treated like telephone orders.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

Can a stamp be used for the physician's signature on physician's orders?

Yes. When rubber stamp signatures are authorized by the facility's management, the individual whose signature the stamp represents shall place in the administrative offices of the facility a signed statement to the effect that he/she is the only one who has the stamp and uses it. Written signatures must be readily available and maintained under adequate safeguards. (42 CFR §483.40(b) Interpretive Guidelines)

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

What is the physician's role in patient care planning? How often must he/she participate or be present?

Federal Guidelines indicate that "the regulation requires the attending physician to participate in the preparation of a plan of care, but it does not require the attending physician to participate in a meeting. The attending physician can accomplish this participation in a meeting or in a number of other ways (e.g. written, telephone or facsimile communications). He or she does not actually have to attend a meeting of the interdisciplinary team. There may be occasions when the physician decides to meet with other health professionals to discuss a particular case, but this will be at the option of the physician."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

Is a doctor's order necessary for supplements?

There is no regulatory basis for requiring a physician's order for supplements. Facility policy must address this issue, and facilities may choose to require such orders. The alternative is to allow the recommendation to be made by the dietitian or by the patient care planning committee.

The following factors need to be considered in determining the appropriate supplement for the patient: the disease process (i.e. diabetes, COPD, renal failure, etc.), therapeutic diet if applicable, presence of decubiti, patient's tolerance level, etc..

Supplements are defined as those products commercially available or prepared in the facility that are provided to meet a specific nutritional need of the patient.

Bulk nourishments are those items (food and/or drink) which are available and routinely offered to all patients.

An "HS snack" is part of the American Dietetics Association diet.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

Some facilities are faxing physician's orders to physicians for their signature, then the signed order is faxed back. Does the original signature need to be on file?

The use of the FAX to transmit physician's orders is permissible. When the FAX is used, it is not necessary for the prescribing practitioner to countersign the order at a later date. Health care facilities should take extra precaution when "thermal paper" is used to ensure a legible copy for the physician's order is retained as long as the medical order is retained, since the print on thermal copies often disintegrates over time.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

Please clarify the frequency of physician visits in nursing facilities now that there is no distinction in the levels of care due to OBRA '87.

Licensure rule 10 NCAC 3H .2501(b) states, “The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.” Because the state rule is more restrictive than the federal regulation, the state rule is controlling.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

There is apparent conflict between Resident Rights, 42 CFR §483.10(b)(4), to refuse treatment and frequency of required physician visits, 42 CFR §483.40(c)(1). Since the advent of the Medicare Program in 1966, there has always been the question of requiring physician visits to privately paying residents at fixed intervals. Now, with the aforementioned paradox in mind, the question can be asked if program patients and/or private patients can refuse physician visits at the specified intervals.

Federal regulation 42 CFR §483.10(b)(4) provides that the long term care facility resident has the right to refuse physician visits that would otherwise be made in accordance with the prescribed schedule in 42 CFR §483.10(c)(1). It is expected that a facility should be able to provide evidence of the resident's refusal of such treatment in a manner that would substantiate that the refusal is, in fact, made at the resident's own initiative. Whenever a resident refuses treatment, it is also expected that the facility will assess the reasons for the resident's refusal, clarify and educate the resident as to the consequences of refusal, offer alternative treatments, and continue to provide all other services.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

If a resident cannot locate a physician to accept him/her as a patient, is the medical director required to add that patient to his/her practice?

No. The medical director is not required to accept a patient into his/her practice because that patient cannot locate a personal physician. Facility staff should make reasonable efforts to assist the resident in locating a physician. 42 CFR §483.75(i)(2)(ii) states "The medical director is responsible for the coordination of medical care in the facility." The medical director's role would include oversight and supervision of physician services and in this case oversight and/or consultation to facilitate the facility's assistance to the resident.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

Define "Physician current orders must be present on the medical record."

Current orders would be any orders that have been prescribed and not discontinued by the physician, automatic stop orders or facility policies.

Can a list of orders be placed on the record to be signed by the physician on his next visit?

Yes, as long as the physician's visit is at least every 60 days. State and federal regulations require physician visits which includes review of the resident's total program of care every 60 days.

Must a list of orders be recopied or reprinted for the attending physician to sign?

There is no specific licensure or certification requirement that physician orders be recopied and reprinted. Licensure rule 10 NCAC 3H .2301(c) states, "All current orders shall be signed and dated by the physician at the time of each visit at least every 60 days." The facility is to have an organized system or procedure that facilitates the review and signing of orders.

Can the attending physician renew orders for signing and dating with a statement "renew current orders?"

A signed and dated statement "renew current orders", is not valid unless preceded by a list of current orders. A recapitulation of current orders is signed and dated every 60 days or each entry (physician's order) is signed and dated every 60 days.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services
DATE: October 1996

Regulations state that facility policy must include notifying the attending physician when a patient expires. If the patient expires at such a time that someone other than the attending physician pronounces the death, can notification of the attending physician wait until the next routine business day?

Yes. Regulations do not specify timing of notification. Licensure rule 10 NCAC .2901(4) states, "The facility shall have a written plan to be followed in case of patient death. The plan shall provide for the following: (4) notification of the attending physician responsible for signing the death certificate."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

Are physical exams by the attending physician required annually?

There is no regulatory requirement for nursing home residents to have annual physical examinations performed by their attending physician. However, the physician's involvement in the resident assessment process is required. The physician's involvement in the annual comprehensive assessment and care planning process is addressed at 10 NCAC 3H .2301(c) and 42 CFR §483.20(d)(2), tag F280.

Please note that in combination homes, the residents of the rest home portion of the facility are required to have annual medical examinations. (10 NCAC 42D .1801) (10 NCAC 42C .2402)

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services
DATE: March 2002

When a Medicaid patient's level of care is changed and an FL_2 is signed by a physician , must there be a physician's order on the chart in addition to the signed FL_2?

No. According to CFR 483.40, "A physician must personally approve in writing a recommendation that an individual be admitted to a facility." As you know, the two levels of care does not need to write an order with each LOC change/submission of an FL_2.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

Page Reserved

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

Page Reserved

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

Please clarify the discrepancy between OBRA regulations (Certification and Licensure) concerning when and what kind of visits PAs/NPs may make and when physicians are required to visit.

Federal regulation 42 CFR §483.40(c) tag F387 states, "The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required."

Licensure rule 10 NCAC 3H .2501(b) states, "Patients shall be seen by a physician at least once every 30 days for the first 90 days and at least every 60 days thereafter. Following the initial visit, the physician may delegate this responsibility to a physician assistant or nurse practitioner every other visit. A physician's visit is considered timely if the visit occurs not later than 10 days after the visit was required.

Required physician visits, after the initial visit, may alternate between personal visits by the physician and visits by a physician extender (i.e., physician assistant, nurse practitioner, or clinical nurse specialist) so long as the physician extender meets all applicable state licensure or certification requirements for that profession, is acting within the scope of practice for that profession under state law, and is under the supervision of the physician.

NOTE: In North Carolina, clinical nurse specialists do not have the authority to perform medical acts.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services
DATE: March 2000

Do physicians have to sign and renew orders at any given interval?

No. According to CFR §483.40(b) - F386, the physician must review the resident's total program of care, including medications and treatments at each required visit; write, sign and date progress notes at each visit; and sign and date all orders. There is no requirement for physician renewal of orders.

RAI

REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

Note: This page replaces page 1 in the RAI section due to change in procedure.

What is the proper procedure for completing Resident Assessment (RAP) summary sheets?

The purpose of the RAP Summary Form is to provide documentation of the information obtained by using the RAP Guidelines for assessment. Instructions for use are listed at the top of the form which consists of four columns. More detailed instructions are listed below.

Column 1
The first column on the left lists the 18 RAPS.

Column 2
This column contains a series of blocks. Check the box (or boxes) in this column that corresponds to the RAP (or RAPS) triggered by the Minimum Data Set.

Column 3
This column is used to note the location of the pertinent information related to a specific resident which has been obtained by using the triggered RAP Guidelines for further assessment. Refer to the instructions at the top of the RAP Summary Form. Number 2 explains in detail the four subjects the documentation should include. Obviously there is not enough space on this form to record all the required information. Therefore, the third column is used to document the location in the medical record of all this information and the date the information was written.

Column 4
This column consists of a series of blocks. It is completed at the time of the development of the care plan. Check the block which corresponds to the RAP (or RAPS) which contains the identified individual problem (or problems) that is addressed on the current care plan. This does not mean that every triggered RAP must be addressed on the care plan. Remember that the summary documentation is going to support the decision regarding proceeding to the care plan or not proceeding to the care plan.

REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

Can nurse aides fill out the MDS form instead of the R.N. Coordinator? The MDS manual indicates the health professionals who can participate in its completion and several examples of health professionals are listed, but not nurse aides.

No. Nurse aides should contribute to the collection of resident assessment data, but the entry of data onto the MDS must be performed by a professional.

REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

Does each discipline that participates in the completion of a MDS have to indicate the sections for which they provided or entered information? What is the regulation (tag number) if a deficiency is cited?

Yes. Federal regulations at 42 CFR §483.20(c)(2), tag F278, require each individual who completes a portion of the assessment to sign and certify its accuracy.

REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

My Resident Assessment Instrument manual states that heights and weights should be rounded to the nearest whole inch or pound, yet state surveyors tell me I should use the actual height and weight. Which is correct?

HCFA's RAI 2.0 manual instructions state: "round height to the nearest whole inch"; "round weight to the nearest whole pound" (page 3-128).

REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

On January 1, 1996 all certified facilities in North Carolina will be required to use the new Resident Assessment Instrument (RAI) Version 2.0. Within what time frame will residents assessed using the old version prior to January 1 have to be assessed using Version 2.0?

All new admissions after January 1, 1996 must be assessed using RAI Version 2.0. All quarterly reviews for any resident must be conducted utilizing the RAI Version 2.0 quarterly form. Residents assessed with the first version of the RAI up until January 1, 1995 must be assessed using RAI Version 2.0 when their annual assessment is due or if they experience a significant change in condition requiring a comprehensive assessment.

REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

Must facilities use a specific, designated printed version of the RAI Version 2.0?

No. Please refer to page 2-2 in the new Resident Assessment Instrument (RAI) User's Training Manual for Version 2.0. "If allowed by the State, facilities may have some flexibility in form design (e.g., print type, color, shading, integrating triggers) or use a computer generated printout of the RAI as long as the State can ensure that the facility's RAI form in the resident's record accurately and completely represents the State's RAI as approved by HCFA in accordance with 42 CFR §483.20(b). This applies to either pre-printed forms or computer generated printouts. States also have the prerogative of requiring facilities to use the State form. Facilities may insert additional items within automated assessment programs but must be able to "extract" and print the MDS in a manner that replicates the State's RAI (i.e., using the exact wording and sequencing of items as is found on the State RAI). Facility assessment systems must always be based on the MDS (i.e., both item terminology and definitions)." North Carolina allows this flexibility.

REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

If a newly admitted resident must return for a temporary stay in the hospital during the first fourteen days of residence, must the completed RAI information be discarded and a new RAI begun? If a new RAI does not have to be initiated, do you add the remainder of the 14 days to establish the date by which the RAI must be completed? For example, the resident is admitted on January 1 and returns to the hospital on January 10. For purposes of RAI, the resident was assessed for 9 days; therefore there are 5 days after return from the hospital to complete the assessment.

Refer to RAI manual page 2-7.

a) If the facility had already completed the assessment before transfer to the hospital, a new assessment would not have to be completed unless the resident experienced a significant change.

b) If the facility had not completed the assessment before the transfer, technically the assessment which had been started could be completed. However, because the same observation period must be used, it may be easier to start a new assessment. It would be possible to use a lot of the sociodemographic and medical history information from the original assessment.

REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

If data has been collected for specific sections of the MDS to the extent required to review (work) a particular RAP, is the facility in compliance if this RAP is completed prior to the assessment date, Section A, Item 3 of the MDS? For example, some RAPs are reviewed and completed at the end of seven days and some are completed at the end of fourteen. The fourteenth day is the day the facility enters in A3 as the assessment reference date.

No. The RAI manual states that the assessment reference date is the "designated endpoint of the common observation period."

REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

Do facilities have to complete a new face sheet for each Resident Assessment Instrument (RAI) done on an annual basis or due to significant change in condition?

The original face sheet may be copied and carried forward to the new MDS being conducted on the annual or significant change RAI.

REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

Does the facility have to indicate on the MDS quarterly review that the care plan has been reviewed and revised? If so, where is this indicated on the 2.0 version?

No. The facility does not have to indicate care plan review and revision on the MDS quarterly review form. The accurately completed plan in and of itself is the documentation of the review and revision.

REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI
DATE: September 1996

Does DMA, DFS or HCFA automatically require a new MDS when a Medicaid resident's level of care changes from ICF to SNF or SNF to ICF?

No. Only when the resident's condition has changed to the degree of significant change (see definition in RAI 2.0 manual) must a new Resident Assessment be performed. If a resident's condition does not change significantly and it is the attempted treatment modalities that change, therefore resulting in a change in level of care, the care plan must be revised to reflect the change in treatment/therapies but a new Resident Assessment (RAI) is not indicated.

REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

The quarterly summary form for RAI Version 2.0 now has the potential to elicit responses to items that would trigger a RAP if entered as a part of an annual assessment. Computer software and certain forms printed by independent vendors will indicate a RAP has been triggered when entering data during a quarterly assessment. Are RAPs a part of every quarterly assessment?

No. Only if the quarterly assessment indicates a significant change in condition has occurred, are RAPs completed. If a significant change occurred, a complete reassessment including trigger RAPs would be required. However, members of the interdisciplinary team may use the RAP guideline to aid in the review and revision of care plans quarterly if desired.

REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI
DATE: August 1999

Can non-professional staff, e.g., admissions coordinators make entries on the MDS?

Yes.

REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI
DATE: March 2000

Can nursing home staff provide palliative care or treatment designed to promote comfort for residents who are not appropriate for rehabilitative care, and do not qualify for the Medicare hospice benefit?

Persons with 6 months or less to live are generally acknowledged to be "terminally ill," and they qualify for the Medicare hospice benefit. Some nursing home residents will suffer the symptoms of incurable, end-stage chronic disease for more than 6 months at the end of their lives. For example, many nursing home residents eventually die from complications of dementing illnesses such as Alzheimer's or multiple strokes, and others suffer from end-stage heart or lung diseases. In the natural course of these illnesses, some residents will reach an end-stage of disease that is irreversible and incurable. Near the natural end of life, persons with these illnesses will typically be unable to walk or participate in self-care even with aggressive staff encouragement and rehabilitation. They often lose their appetite, reduce intake, and lose weight in the final stages of illness.

Nursing home residents and their families may elect an approach to care that maximizes comfort and minimizes suffering during the final phase of any severe chronic or terminal illness. Nursing home staff, together with residents and families, may create palliative care plans or treatment plans designed to promote comfort when rehabilitation is not possible or appropriate to the resident's wishes and needs. According to OBRA 1987, skilled nursing facilities must "…provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." This set of goals is met for residents who are progressively declining toward death by using care plans that differ from care plans for residents who are expected to improve with rehabilitation. A palliative plan of care is most appropriate when the primary goals of treatment are to ensure comfort, improve psychosocial well-being, and maximize quality of life. The critical steps in designing and implementing an appropriate palliative care plan is individualized resident assessment and careful communication and goal-setting with resident and family.

Facilities should document the following process to arrive at an appropriate palliative care plan for a resident with end-stage chronic or terminal illness, whether or not they are enrolled in hospice care.

a) Physician documentation of the life-limiting disease diagnosis and end-stage prognosis.
b) Nursing and therapy team assessment of resident's functional status decline, and the failure of rehabilitative measures to improve functional status.[1]
c) Interdisciplinary care planning with resident and family, to discuss diagnosis, prognosis, and appropriate goals of care; resident and/or family should express the resident's desire for a natural death, and his or her wish to create a care plan focused on quality of life and comfort.
d) Nursing and social work assessments of palliative care needs -- physical pain and other symptoms, emotional, social, and spiritual sources of suffering.
e) Chart documentation of palliative care plan of treatment designed to improve comfort and quality of life.
f) Chart documentation of a discussion of treatment preferences, and physician orders to respect preferences, including Do-Not-Resuscitate orders, Do-Not-Hospitalize orders, orders to forego other life-prolonging treatments such as tube-feeding or antibiotics, orders to give comfort treatments such as pain medication, and other supportive measures.

[1] If the patient is in a Medicare/Medicaid bed, the Resident Assessment Instrument and protocols (RAPs) should be used accordingly. When working "RAPs" triggered by the required MDS, the assessor can note how rehabilitation and restorative measures would not be beneficial nor appropriate interventions for goals such as comfort and psychosocial well-being of the individual.

RESTRAINTS

RESTRAINTS

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

A patient is weak, unsteady on her feet, and confused. The physician, family and care team have "weighed the risks and benefits" and decided it would be best to use physical restraints. When the patient begins to regain her strength, her confusion lessens, and the staff feels more comfortable with her ambulating independently, and the staff discontinues use of the restraint. If the patient then falls and breaks her hip, is the staff liable?

Initiation and/or discontinuing a physical restraint must be based on the resident's medical needs and must be ordered by a physician. The answer to this question will depend on many factors, such as whether the facility was acting pursuant to a physician's order in removing the restraint, whether the physician acted properly in issuing such an order, whether both the order and the resulting action were consistent with the prevailing medical standard of care, and so forth. Physicians and facilities both have a duty to residents to act with due care and in accord with the prevailing medical standard of care. Whether that duty has been met or not depends on the unique facts of each case. It also depends on whether a judge or jury believes the physician's and the facility's actions were consistent with the prevailing medical standard of care. It is impossible to predict accurately in any specific case whether a facility will incur civil liability for injuries to a resident.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

A provider is trying to reduce restraints by means of lesser methods. What is the legal implication for the provider if the resident falls under lesser method when a physician's order on the chart calls for a more restrictive restraint? How should the provider handle this potential situation with a physician?

It is not within the parameters of the RFB Committee to address legal issues providers may encounter. However, it is required that efforts be made to use the least restrictive measures. If the physician is insistent that a more restrictive restraint be used, documentation must support the need as well as involvement of the resident, family member or legal representative. Where conflicts arise, involvement by the medical director may be necessary.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

What if an Alzheimer's patient constantly wanders to the point of exhaustion? Can the patient be restricted at times so he/she can get some rest?

There are times when restraints may be appropriate. The patient care planning process should provide for an assessment of what is needed under differing circumstances or resident behavior patterns and care plan accordingly.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Can a facility be cited for using a restraint that is made by a different manufacturer than one cited in the physician's order?

Restraint orders are to be specific as to type of restraint used. An order such as "Posey Restraint when OOB in chair" is not acceptable because it indicates the manufacturer, not the type of restraint.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Regarding the statement in surveyor guidance regarding "did the resident or legal representative consent to use of restraints and is this documented" - what specific consent is the surveyor looking for?

Specific consent regarding restraint use must be obtained from the resident or legal representative at the time a decision to utilize a restraint is made by the interdisciplinary team. There is no requirement that this consent be documented in any specific format but there must be evidence that discussions have taken place.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Can a resident be restrained in a non-mobile chair or is the facility required to use only chairs with wheels for restraining?

Regulations do not govern the type of chair selected by the care planning team.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Is a geri-chair a restraint if you take the table/tray off? What if the patient can't move but wants the geri-chair table/tray to hold personal items (e.g., Kleenex)? Would the use of a geri-chair for meals and activities be considered a restraint or an enabler?

When geri-chairs are utilized with or without the table/tray to restrict freedom of movement or mobility they are considered restraints. In the event that the geri-chair is used as a positioning device for an immobile patient (or the tray used at the patient's request per se), all measures to prevent functional decline must be implemented including, but not limited to, release and repositioning. In both circumstances the use of the geri-chair must be incorporated into the care planning process.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

What is acceptable evidence of consultation with appropriate health professionals (i.e., physical therapists, occupational therapists, etc.) in the use of less restrictive supportive devices prior to using physical restraints?

Documentation in the medical record (for example, the comprehensive care plan). There should be evidence of review and revision as applicable.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

A physician's order reads "may restrain with geri-chair with tray and/or vest restraint for patient's safety. Check every 30 minutes and release every two hours." Is it possible for the charge nurse to apply a lesser restraint (e.g., soft waist) without a new physician's order?

No. If, after evaluating the resident, the nurse determines that a less restrictive restraint is appropriate, the physician must be advised and a change in the restraint order obtained.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Can surveyors "mark" restraints?

Surveyors can mark restraints by using pen, pencil, paper or tape to monitor release and positioning. If a pen is used it must have washable ink. Surveyors must maintain the dignity of the patients when marking the restraints. For example, if the resident is alert and oriented, the surveyor should explain what they are doing and why.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

What do you do if a resident's family requests restraints even though they have not been ordered by the physician?

Restraints are only applied after a thorough assessment of need, a trial of less restrictive measures, and only with a physician's order. Restraints are not to be applied solely at the request of a family member.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Can restraints be tied to the siderails of beds?

No. Restraints are not to be tied to siderails. Siderails can slip and fall, causing injury to the patient.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

If a patient is in a geri-chair and is wearing a vest restraint, is this a "double restraint" and therefore a violation of the patient's rights?

There is no regulatory terminology that refers to "double restraints." As long as both restraints are ordered by a physician, and the use of the restraints has been assessed and justified by the facility, then it is not seen as a patient's rights violation.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Is it appropriate/permissible to use sheets as restraints?

Although the use of sheets is discouraged by the Division and nursing home industry as a whole, there is no specific regulatory authority prohibiting their use. If facilities wish to use sheets as restraints they must have a physician's order for their use and policies that specifically address their use. Policies should, at a minimum, address in what circumstances they will be used and how they will be applied. As with any restraints, improper application and use can cause injury to patients.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Can a patient who is alert and oriented be restrained because the family wants him/her restrained? Can the family refuse restraints on the behalf of an alert and oriented patient?

No. An alert, oriented resident who is his own legal representative has the right to make decisions regarding restraints regardless of family opinion.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

How do we address restraints on care plans?

Neither state or federal statutes nor regulations dictate how a facility should conduct its care planning or what the care plan should look like. However, the federal regulations at 42 CFR §483.13(a) address facility requirements when using restraints. Interpretive Guidelines at tag numbers F221 and F222 describe in detail the factors which the facility should consider in determining when and how to utilize restraints as well as considerations
for care planning.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

If a nonambulatory resident wears a lap belt or a vest, or is placed in a geri-chair with a tray to prevent him from falling out of the chair, is this still considered a restraint?

The federal regulations define a restraint as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body which the resident cannot easily remove, which restricts freedom of movement or access to his or her body. The Interpretive Guidelines at tag numbers F221 and F222 state that "When coupled with appropriate exercise, therapeutic interventions such as pillows, pads, or removable lap trays, are often effective in achieving proper body position, balance and alignment, and preventing contractures without use of restraints." This language indicates that such pillows, pads, lap trays, etc. may not be considered restraints in some cases. Instead, they may be viewed as alternatives to restraints.

If a lap belt, vest or geri-chair tray can be easily removed by the resident, these items would not be considered a restraint within the meaning of the federal regulations. Typically, a vest is not easily removed by the resident and would, therefore, normally be considered a restraint. However, each resident must be assessed on an individual basis to determine if the device being used meets the federal definition of a restraint.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Is a reclining chair a restraint? Do you need to have a physician's order?

The federal regulations define a restraint as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body which the resident cannot easily remove, which restricts freedom of movement or access to his or her body. The Interpretive Guidelines at tag number F221 and F222 state that "When coupled with appropriate exercise, therapeutic interventions such as pillows, pads or removable lap trays, are often effective in achieving proper body position, balance and alignment, and preventing contractures without use of restraints." This language indicates that such pillows, pads, lap trays, etc. may not be considered restraints in some cases. Instead, they may be viewed as alternatives to restraints.

If a reclining chair restricts the resident's body so that he or she cannot easily move, and the resident cannot remove the restriction easily, then the reclining chair would be considered a restraint and would require a physician's order. Because of the manner in which the federal regulations define restraint, each resident must be assessed on an individual basis to determine if the device being used meets the federal definition of restraint.

When residents are physically incapable of initiating any voluntary movement and the reclining chair is an alternative to bedrest, the reclining chair is not considered a restraint.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Are bed cover retainers restraints?

The bed cover retainers are not considered a restraint when applied to assist the resident in maintaining privacy and dignity by insuring proper covering of the resident. However, when bed cover retainers are applied and limit the resident's freedom of movement or a resident's access to his or her body, then the bed cover retainer would be considered a restraint.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Can a positioning pillow be used at the facility without being considered a restraint? The pillow slides under the arms of a wheelchair and fits snugly but can be pushed out of place with minimal effort. Does the facility need a physician's order to use this type of positioning device?

The federal regulations define a restraint as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body which the resident cannot easily remove, which restricts freedom of movement or access to his or her body. The accompanying Interpretive Guidelines at tag number F221 and F222 state that "When coupled with appropriate exercise, therapeutic interventions such as pillows, pads or removable lap trays, are often effective in achieving proper body position, balance and alignment, and preventing contractures without use of restraints." This language indicates that such pillows, pads, lap trays, etc. may not be considered restraints in some cases. Instead, they may be viewed as alternatives to restraints. However, because of the manner in which the federal regulations define restraint, each resident must be assessed on an individual basis to determine if the device being used meets the federal definition of restraint. If the positioning pillow described in the question is easily removable by the resident, it would not meet the definition of restraint. As such, no physician's order is required for the use of such devices.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

What is to be done when a patient emergency occurs which calls for a physical restraint, but there are no physician's orders for a restraint?

When a patient emergency occurs for which a restraint is necessary to alleviate an immediate and serious danger to the resident or other persons in the facility, minimum effective restraint measures may be applied for brief periods in accordance with nursing judgment when it is not possible to contact the physician to report the significant change in the patient's condition and obtain instructions from the physician. Orders for emergency use must be obtained or confirmed in writing as soon as possible. (Please refer to federal interpretive guidelines for tags F221 and F222.)

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Are siderails considered a restraint? What if the facility has the half siderails like in hospitals and the patient can still get out of bed without putting them down? Do we need a release signed? Is a siderail considered a restraint or a safety device?

Please see the attached HCFA transmittals (HCFA All-States Letters 87-93 and 99-93) which specifically address this issue.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

A resident's mental capacity is such that they are unable to understand, retain or utilize safety techniques and training so as to prevent self-injury such as falling. The person's gait is unsteady and she is in constant motion. Would the use of a restraint be appropriate under federal guidelines for this resident? The resident is diagnosed with Alzheimer's.

Restraints are only appropriate when required to treat medical symptoms and when less restrictive measures have been ruled out. Restraints can never be used for purposes of discipline or convenience. When determining medical necessity for restraints, causal factors must be considered.

Given the causal factors and the absence of a way to remove them, the risks and benefits of restraint usage must be determined and explained to the resident (surrogate when appropriate). If the risks are great for self inflicted injuries, pain and suffering, i.e., fractures, head and facial injuries, or surgery restraint use may be warranted.

The least restrictive intervention that will enable a resident to attain or maintain his/her highest practicable level of functioning should be employed. Restraints can have negative impacts. Restraints can be an accident hazard, a serious affront to the dignity of the resident, and they can lead to urinary and fecal incontinence, pressure sores, loss of muscle tone, loss of independent mobility, increased agitation, loss of balance, symptoms of withdrawal or depression, reduced social contact, and decreased appetite. Prior to using a restraint, federal regulations require the facility to have evidence of consultation with appropriate health professionals. This may include occupational therapists and physical therapists who can assist with identifying appropriate alternatives to restraints. Also, according to State law, any physical restraint must be authorized by a physician. If restraints are determined to be necessary, the resident's care plan must include measures to minimize the potential negative impacts.

Note: Emergency use of restraints is addressed in the federal requirements and interpretive guidelines.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

When is the use of a mechanical or physical device attached or adjacent to the resident's body that restricts movement considered to be an enabler?

Restraining devices are considered to also be enablers when they enhance functional ability in the least restrictive manner.

Examples include but are not limited to:

1. A seated walker when, without its use, the resident's mobility would be further restricted or risk for injury increased.

2. A reclining chair when, without its use, the resident's condition would limit their positioning to a bed or wheelchair.

3. Devices that enable residents to maintain optimal anatomical position to prevent discomfort and/or deformities caused by immobility such as contractures, e.g., positioning is enhanced by supporting the pelvis or upper trunk or extremities.

If these enabling devices are used when patients cannot remove or release themselves, the same assessment and planning process must be used to determine that their use is least restrictive and medically justified as with a device that is used solely to restrict movement. Documentation must support the assessment, planning and evaluation. A thorough review of the Resident Assessment Protocol (RAP) for restraints as well as a thorough review of the interpretive guidelines for §483.13.13(a) Tags F221 and F222 are essential to an appropriate assessment process.

For bedrails, it is also helpful to refer to the definition found in the Long Term Care Facility Resident Assessment Instrument (RAI) User's Manual, Chapter 3, Item G-6 on Page 3-99. "Bed rail(s) used for bed mobility or transfer -- refers to any type of side rail(s) attached to the bed USED by the resident as a means of support to facilitate turning and repositioning in bed, as well as for getting in and out of bed. **Do not check this item if resident did not use rails for this purpose.**

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints
DATE: January 1996

What are some examples of restraint reduction?

Restraint reduction must be a result of assessment and planning for each individual resident. If discontinuance of a restraining device is ruled out based on the resident's medical condition, the speed and degree of reduction that is implemented is driven by the individual resident's need.

Examples include but are not limited to:

1. Reducing gradually the amount of time the resident is restrained and increasing the unrestrained periods based on the observations made during the time the restraint is off. Restraints are logically removed during periods of increased observation.

2. Trying an alternative device that is less restrictive such as orthotic devices or a different type of chair in the place of a vest restraint.

Documentation must support the assessment and determination of the resident's medical indication or need for restraints and the rationale for the reduction process chosen. A thorough review of the Resident Assessment Protocol (RAP) for restraints as well as a thorough review of the interpretive guidelines for §483.13(a) Tags F221 and F222 are essential to an appropriate assessment process.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints
DATE: October 1996

Please define assistance devices and supervision in relation to Tag F324.

Assistance devices are the same as assistive devices. Supervision is evaluated in the context of identifying needs and risk; planning; and implementing approaches to meet those needs and manage those risks.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

If a resident has had a physical therapy evaluation for restraints prior to the time of discharge and is readmitted a month later - does the resident need a new physical therapy evaluation or is it permissible to pull the old physical therapy evaluation from medical records and update it?

There is no requirement for a physical therapy evaluation per se. The determination as to the need for a new resident assessment must be based on the guidelines for significant change and facility policy. The need for repeating the restraint evaluation would be based solely on the interdisciplinary team's findings. This team should include the physician and the resident (and/or family representative). The team will determine whether the previous P.T. evaluation continues to meet the needs of the resident.

If the previous P.T. evaluation is utilized by the team, it may be copied from the old record to be signed and dated as an entry into the new record.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

If a physician orders a restraint (chemical or physical), can the provider then use the restraint or does the facility have to prove that they have tried less restrictive measures? What if the physician is insistent on the restraint only? What about potential conflict of facility staff practicing medicine?

State law and federal regulation prohibits the use of restraints for purposes of discipline or convenience, and allows restraints to be used only to treat a medical need. State law also requires that the facility conduct an evaluation to ensure that the least restrictive means of restraint are used on those residents who require restraints.

Therefore, before using a particular restraint ordered by the resident's physician, the facility must evaluate the resident to determine whether the resident requires a restraint and, if so, whether there is a less restrictive restraint than the particular restraint ordered by the physician. If the patient's evaluation shows that a restraint is needed, but that there is a less restrictive restraint than the restraint ordered by the physician, the physician should be advised accordingly. If the physician insists that an inappropriate restraint be used, it may be necessary to involve the medical director or others to convince the resident's physician to change his/her order. If the physician still insists on an inappropriate restraint, the facility has the right, after informing the resident or responsible party, to seek an alternative physician. The licensure rules require physicians to follow state and federal requirements for physician's services to insure that the resident receives appropriate care and treatment.

SANITATION

REGULATORY FOCUS BULLETIN

FILE TOPIC: Sanitation

What is acceptable procedure for storage of ice scoop holders? Do they have to be covered?

Ice scoop holders should be covered when not in use. A scoop guard or other mechanism that allows for drainage of H_2O is needed to prevent the scoop from sitting in the H_2O where bacterial growth could occur.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Sanitation

Is it acceptable to use a community brush for cleaning toilet bowls and bedpans?

Yes.

Can containers of Clorox and water used for cleaning be stored in bathrooms?

No. Cleansing agents must be properly labeled and stored out of reach of patients.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Sanitation

Can a container for the collection of soiled bibs accompany the food cart at pick up time?

Yes, covered containers of soiled bibs may be in the area of food trays at pick up time.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Sanitation

Are paper towels required to be under collector containers (which are sitting on the floor) when emptying foley catheters?

No. Appropriate infection control procedures during collection and disposal are required. This includes handwashing after the urine is discarded and the receptacle rinsed and replaced.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Sanitation

Should dirty items such as emeses basins, bed pans, shaving cups, etc, ever be cleaned in the facility's dishwasher where sanitized eating utensils are cleaned?

No.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Sanitation

If electric razors are used by more than one patient, what procedures must be followed?

a) The razor must be wiped between each patient use with a clean cloth moistened with 70 percent by volume isopropyl alcohol or other disinfectant approved by the Environmental Protection Agency for this purpose.

b) Razors should not be shared between patients where there is a chance of transmission of blood borne diseases due to open face lesions or other similar conditions.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Sanitation

What is the proper storage and safety of personal care items?

Personal care items (e.g., toothbrushes) should not be co-mingled with other patient care items. An individual's personal care items can be stored together as long as all items are clean. For examle, a clean, appropriately covered toothbrush can be stored with other items. A toothbrush may also be stored in a separate bag.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Sanitation

Page Reserved

SURVEY PROTOCOL

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol

What is the survey agency's position on legal disclaimers at the end of the plan of correction? Why?

A facility has the right to include a disclaimer on their plan of correction. A disclaimer does not relieve the facility of its responsibility for submitting a plan of correction and for correcting problems.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol

Is it a requirement for a certification team to measure the degree of elevation of the head of a tube feeding patient with an angle drawn on a piece of paper? Is measuring elevation a new practice?

It is not required that a surveyor measure for the precise number of degrees of elevation of the head of a resident's bed. Reasonable approximations are acceptable. It is customary nursing practice to elevate the head of the bed unless contraindicated at least one hour post feeding.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol

Can surveyors place items underneath a resident or between the resident's legs in order to monitor care?

No. Foreign objects are not to be used in order to monitor care.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol

What is the time frame for issuing a survey report to the facility after the exit conference?

Licensure and Certification reports shall be issued to the facility within 10 working days from the date of the exit conference.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol

What is an appropriate way to announce the survey team's arrival to the facility?

It is appropriate to announce the team's arrival over the facility intercom system if desired. A suggested format is as follows: "Good morning. It is (date). The survey team from (agency/section) has arrived to conduct a (type) survey. The survey team is led by (name). Will (staff of Administrator's choice) please report to (location)..."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol

During a standard survey, can surveyors collect data prior to the date of the previous standard survey and utilize that data in a deficiency?

Yes. Historical data can be utilized in a deficiency, if it is pertinent and helps support the deficiency. However, the deficiency itself should be based on deficient practice(s) that has been occurring, or has occurred, since the last survey and not prior to the previous survey.

What surveyors can not do is collect data from the previous survey for the sole purpose of elevating scope and harm.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol

Appendix P of the State Operations Manual defines an interviewable resident as one who "has sufficient memory to be able to answer coherently the majority of questions contained in the Resident Interview and make day to day decisions in a fairly consistent and organized manner." If the facility identifies a resident as interviewable based on the preceding definition, and later a statement/claim made by the resident in an interview with a surveyor is felt by staff to be inaccurate, is the inaccurate statement automatically discounted because the resident was identified by the facility as interviewable?

No. Every possible effort should be made by surveyors to determine the validity of information provided by interviewable residents. However, statements made by, and information given by reliable and creditable residents may be the key factor, or in a few instances, the sole factor in reaching decisions relative to citing deficiencies.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol

Should surveyors communicate names of specific residents during the survey?

Yes, unless the information is obtained during a confidential interview.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol

What is appropriate protocol for surveyors and facility staff during the initial tour of the facility?

Detailed information regarding appropriate procedures and objectives during the initial tour of a standard survey can be found on Page 14-17 in the State Operations Manual.

During the tour surveyors gather information about concerns which have been preselected; new concerns discovered onsite; and whether residents preselected for the Phase 1 sample offsite are still present in the facility. The surveyor attempts to meet and talk with as many residents as possible in order to identify other candidates for the sample, to get an initial overview of facility care and services, to observe staff resident interactions and to evaluate the impact of the facility environment on the residents.

It is desirable for a staff member to accompany the surveyor during the tour to answer questions and provide information. It is appropriate for the facility staff to remain outside of the resident's room or "down the hall" to provide the surveyor an opportunity to interact with the resident and/or family.

The tour will begin very soon after the entrance and will not be delayed while awaiting staff arrival.

The tour will begin as soon as possible after entering the facility.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol

Are follow-up deficiency reports considered the most recent survey?

No. The interpretive guidelines state: "Results of the most recent survey means the Statement of Deficiencies (HCFA-2567) and the Statement of Isolated Deficiencies generated by the most recent standard survey and any subsequent extended surveys, and any deficiencies resulting from any subsequent complaint investigation(s)."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol
DATE: June 1997

What are the requirements for maintaining a complaint file?

There is no specific requirement for the facility to maintain a grievance file. The regulation does require prompt efforts by the facility to resolve grievances. "Prompt efforts"...to resolve include facility acknowledgement of a complaint/grievance and actively working toward resolution of that complaint/grievance.

The facility must show evidence to surveyors that they have acknowledged a complaint/grievance and have evidence they are actively working toward resolution of the grievance or complaint. It is up to the facility to record this information in the manner they choose. Refer to F165 to F166 and Interpretive Guidelines.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol
DATE: July 1997

Are skin tears included in Item 6 of the resident roster “abrasions...?”

Yes.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol
DATE: September 1997

According to an AHCA memo from 1995, we are no longer required to provide surveyors with accident or incident reports. Is this still correct? Can surveyors ask to see the reports if there is a question about a particular resident?

There are too many variables for a "yes" or "no" answer to the first question. The facility is required to show evidence that on a routine basis it monitors accidents and other incidents, records these in clinical or other records, and has in place a system to prevent and/or minimize further accidents and incidents. Refer to Page 9 of Appendix P. If the facility uses accident/incident reports as their only method to record any of the above components, then the surveyors would need to review the reports as evidence of meeting the participation requirements. If the facility uses accident/incident reports and/or additional methods, then the surveyors can review the "other methods" for evidence for meeting participation requirements.

In answer to the second question, however, the facility has the option of producing necessary evidence regarding a particular incident other than an accident/incident report. When the situation warrants, the facility must also produce evidence of what they are going to do to prevent or minimize further incidents/accidents.

Note: Sometimes an accident/incident report may contain the only evidence of meeting other regulatory requirements. If so, the facility would want to produce the report as evidence of compliance.

NOTE: Facilities are not required to maintain accident/incident reports.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol

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REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol
DATE: March 1998

Can surveyors inspect any resident's record and have copies of those records when the resident resides in a certified Medicare and/or Medicaid bed (disregard payment source)?

Yes. §489.53

Can surveyors inspect any resident's record and have copies of those records when the resident resides in a licensed only nursing home bed?

Yes, unless the resident has objected in writing to review that resident's record.
§131E-105

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol
DATE: March 2000

Does the survey Roster Sample Matrix have to be completed by the facility now that surveyors have a computer-generated facility profile?

Yes. The computer-generated facility profile that surveyors have may not be as current as facilities are only required to submit MDS data once a month.